

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04358

CERTIFICATE OF DEATH

04359

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN Tb 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEAL ISLAND 19-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital						d. STREET ADDRESS MAIN ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First		Middle W.		Last Abbott		4. DATE OF DEATH Month MARCH Day 11 Year 1967	
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 17-1909		9. AGE (In years lost and day) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATERMAN		10b. KIND OF BUSINESS OR INDUSTRY SEA FOOD		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WILLIAM C. ABBOTT		14. MOTHER'S MAIDEN NAME VIRGINIA WEBSTER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MAGGIE ABBOTT DEAL ISLAND MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2021 IMMEDIATE CAUSE (a) Lymphoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Months			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town)		20g. (County)		20h. (State)		21. I certify that (I) (this hospital) attended the deceased from 3/10/1967 to 3/11/1967 , that (I) (we) last saw the deceased alive on 3/11/1967 and that death occurred at 2:22 M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 3/11/67		22c. PHYSICIAN'S NAME (Type) Leroy Webster - Princess Anne		22d. ADDRESS St. John's		22e. REC'D BY REGISTRAR MAR 16 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/14/67		23c. NAME OF CEMETERY ST. JOHN'S		23d. LOCATION (City or Town) (County) (State) DEAL ISL SOM. MD		23e. REGISTRAR'S SIGNATURE [Signature]	

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04359

CERTIFICATE OF DEATH

04360

1. PLACE OF DEATH a. COUNTY Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		23-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS R. F. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last GRANVILLE L. Adams				4. DATE OF DEATH Month Day Year MARCH 10 1967			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 9, 1900	
9. AGE (In years last birthday) 66 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) F. SHERMAN		11. BIRTHPLACE (County & State, or foreign country) WEST NORFOLK VA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PERCIVAL S. ADAMS				14. MOTHER'S MAIDEN NAME MALE (2)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 22E-14-7296		17. INFORMANT Mrs G. Adams Ocean City MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate metastatic 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Carcinoma of prostate DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965, 1945 to 2/10, 1967, that (I) (we) lost the deceased alive on 2/10 1967, and that death occurred at 4:15 PM, from causes and on the date stated above							
22a. SIGNATURE Walter DeWally				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/14/67		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOOD MD	
24. FUNERAL DIRECTOR Anna H. Burboye				ADDRESS 250. REC'D BY REGISTRAR MAR 16 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATION AT TROUSERS

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04360

CERTIFICATE OF DEATH

04361

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Pocomoke City</u> d. STREET ADDRESS <u>R.F.D. 3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Reginald James Adams</u> First Middle Last			4. DATE OF DEATH <u>March 29 1967</u> Month Day Year				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 9, 1910</u>	9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (County & State or foreign country) <u>Somerset County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Adams</u>			14. MOTHER'S MAIDEN NAME <u>Jennie Long</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-18-5595</u>		17. INFORMANT Address <u>R.F.D. 3</u> <u>Mrs Margaret Adams, Pocomoke, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary Arteriosclerosis</u> (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3/26/1967</u>, to <u>3/29/1967</u>, that (I) (we) last saw the deceased alive on <u>3/28/1967</u> and that death occurred at <u>9 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>			22b. DATE SIGNED M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <u>Oswald J. Burton, M.D.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>3-31-1967</u>		23c. NAME OF CEMETERY <u>First Baptist</u>		
23d. LOCATION (City or Town) <u>Pocomoke City</u>			(County) <u>Wor.</u>		(State) <u>Md.</u>		
24. FUNERAL DIRECTOR <u>Robert H. Watson</u> <u>Robert H. Watson</u>			25a. REC'D BY REGISTRAR <u>APR 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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UNITED STATES DEPARTMENT OF AGRICULTURE

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VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04361											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution. Reside in before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
c. LENGTH OF STAY IN 1b						d. STREET ADDRESS <u>683 Fitzwater St.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>683 Fitzwater St.</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Carl F. Bailey</u>						4. DATE OF DEATH <u>March 25, 1967</u>					
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1890</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Bailey</u>						14. MOTHER'S MAIDEN NAME <u>Jennie ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. 17. INFORMANT <u>Gladys Stewart 129 Second St. Salis-Md.</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Renal Disease</u>											
Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u>											
(a), stating the underlying cause last, (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>25 Dec 1966</u> to <u>25 Mar 1967</u> , that (I) (we) last saw the deceased alive on <u>25 Mar 1967</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>F. A. Parnell</u>						22b. DATE SIGNED <u>28 Mar 67</u>					
22c. PHYSICIAN'S NAME (Type) <u>F. A. Parnell, M.D.</u>						22d. ADDRESS <u>652 W. MAIN ST., Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3/29/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE			
ADDRESS <u>Salis - Md.</u>						DATE <u>MAR 30 1967</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04362											
Item #4-1111 #G307 3722101 bc											
04364											
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Wicomico</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mardela</i>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mardela</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>R D I</i>						d. STREET ADDRESS <i>R D I</i>					
3. NAME OF DECEASED (Type or print) <i>Edwin D. BAILEY</i>						4. DATE OF DEATH Month <i>March</i> Day <i>9</i> Year <i>1967</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>April 8, 1889</i>		9. AGE (In years last birthday) <i>77</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Boats</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>				12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>Samuel Bailey</i>						14. MOTHER'S MAIDEN NAME <i>Nancy English</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>213-12-5927</i>		17. INFORMANT <i>Lola Russell Bailey</i>				Address <i>Mardela, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <i>34 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>65</i> , to <i>3/9/67</i> , 19__, that (I) (we) last saw the deceased alive on <i>3/9/67</i> 19__, and that death occurred at <i>5 P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>H. S. Kahlman</i>						22b. DATE SIGNED <i>3/10/67</i>					
22c. PHYSICIAN'S NAME (Type) <i>H. S. Kahlman</i>						22d. ADDRESS <i>Sharptown</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/12/67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Reverton Cem.</i>				23d. LOCATION (City, town or county) (State) <i>Reverton Md.</i>			
24. FUNERAL DIRECTOR <i>William M. Mowel</i>						ADDRESS <i>Delmar Del.</i>				25. REC'D BY REGISTRAR <i>Mar 14 1967</i>	
						26. REGISTRAR'S SIGNATURE <i>William M. Mowel</i>					

MEMO

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04363

CERTIFICATE OF DEATH

04365

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>Route #1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>Huttie ETHEL Bull</u> First Middle Last			4 DATE OF DEATH <u>March 21</u> 19 <u>67</u> Month Day Year				
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Jan. 31 1888</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR SEWING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEWING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>			
13. FATHER'S NAME <u>JAMES G. TAYLOR</u>			14. MOTHER'S MAIDEN NAME <u>MARY ELLEN MILES</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>120-01-2997</u>		17. INFORMANT <u>MRS. BERNICE TRUITT</u> Address <u>Snow Hill, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reperforated abdominal aneurysm</u> DUE TO (b) <u>Chronic atherosclerosis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Large fungating carcinoma face, nose & eye</u>					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>3-20</u> , 19 <u>67</u> to <u>3-21</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-21</u> , 19 <u>67</u> , and that death occurred at <u>7:50</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>H. P. Brille</u>			22b. DATE SIGNED <u>3-27-67</u>		22c. PHYSICIAN'S NAME (Type) <u>H. P. Brille</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>MAR. 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NELSON CEM. VA.</u>		
24 FUNERAL DIRECTOR <u>Swaid & Brundage Snow Hill Md.</u> ADDRESS _____			25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE		
25c. LOCATION (City or town) (County) (State) <u>Snow Hill Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04364

CERTIFICATE OF DEATH

04366

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Virginia b. COUNTY Accomack	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Chincoteague	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 110 Jester Street	
3. NAME OF DECEASED (Type or print) First Middle Last Lenora Jeanette Birch		4. DATE OF DEATH Month Day Year March 1 1967	
5 SEX Female	6 COLOR OR RACE W.B. Te	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 10, 1893
9 AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Self	
11 BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ruben Bishop		14. MOTHER'S MAIDEN NAME Margaret Whealton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 180-14-2931	
17 INFORMANT Ansley Birch, Chincoteague, Virginia		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 466X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Thrombophlebitis multiple migrating DUE TO (c) Cause unknown			INTERVAL BETWEEN ONSET AND DEATH years.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) leukocytosis & thrombocytosis post splenectomy 1965			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 02-07-67 , 19__, to 03-1-67 , 19__, that (I) (we) last saw the deceased alive on 03-1-67 19__, and that death occurred at 7:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE Joseph C. Fitzgerald		22b. DATE SIGNED March 1, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Medical Center	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Mechanics Cemetery	23d. LOCATION (City or Town) (County) (State) Chincoteague, Virginia
24. FUNERAL DIRECTOR Salyer Funeral Home, Chincoteague, Virginia		25a. REC'D BY REGISTRAR DATE MAR 3 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

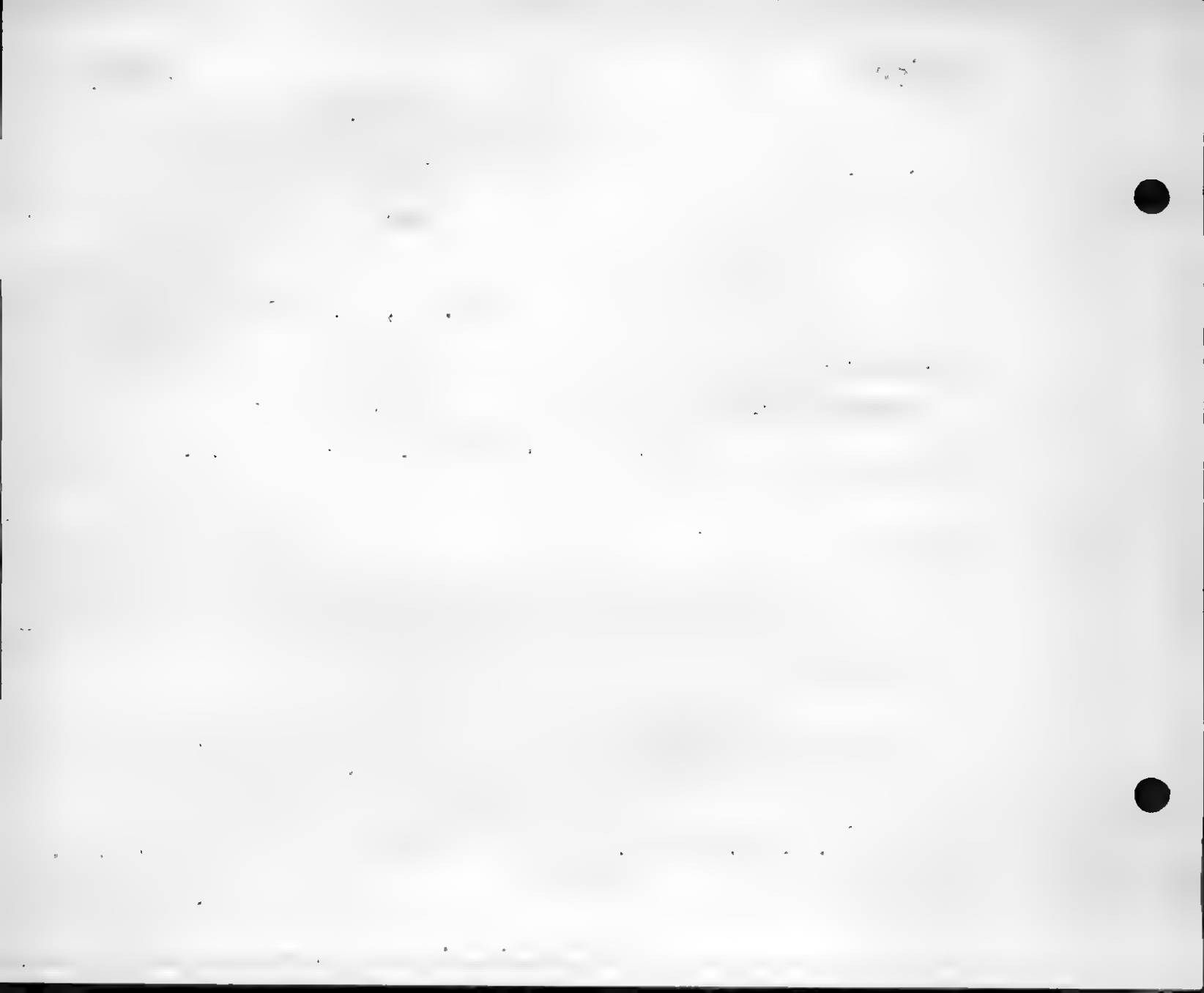
04365

CERTIFICATE OF DEATH

04367

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓						
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>621 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>					d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED First Middle Last <u>Garrett</u> <u>Black</u>				4 DATE OF DEATH Month Day Year <u>March</u> <u>14</u> <u>19 67</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Jan. 21, 1891</u>		9. AGE (In years last birthday) yrs. <u>76</u>		
10a. US. JO. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Horney Black</u>					14. MOTHER'S MAIDEN NAME <u>Alice Hexter</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>218-20-9110</u>		17. INFORMANT Address <u>John H. Black Ridgely, Maryland</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary embolism</u> 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u>Arteriosclerosis obliterans</u>								INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 hours</u> Years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right above-knee amputation; blindness</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (this hospital) attended the deceased from <u>July 1, 1965</u> , to <u>March 14, 1967</u> , that (we) last saw the deceased alive on <u>March 14, 1967</u> , and that death occurred at <u>2:20 P.</u> from causes and on the date stated above.										
22a. SIGNATURE <u>C. H. Winnacott</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3/14/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>C. H. Winnacott, M. D.</u>					22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u>					
23a. BURIAL, CREMAT. OR REINTERMENT <u>Burial</u>			23b. DATE THEREOF <u>3-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>			23d. LOCATION (City or Town) (County) (State) <u>Goldsboro, Maryland</u>		
24. FUNERAL DIRECTOR <u>J. E. Boulesis</u>					ADDRESS <u>Greensboro, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

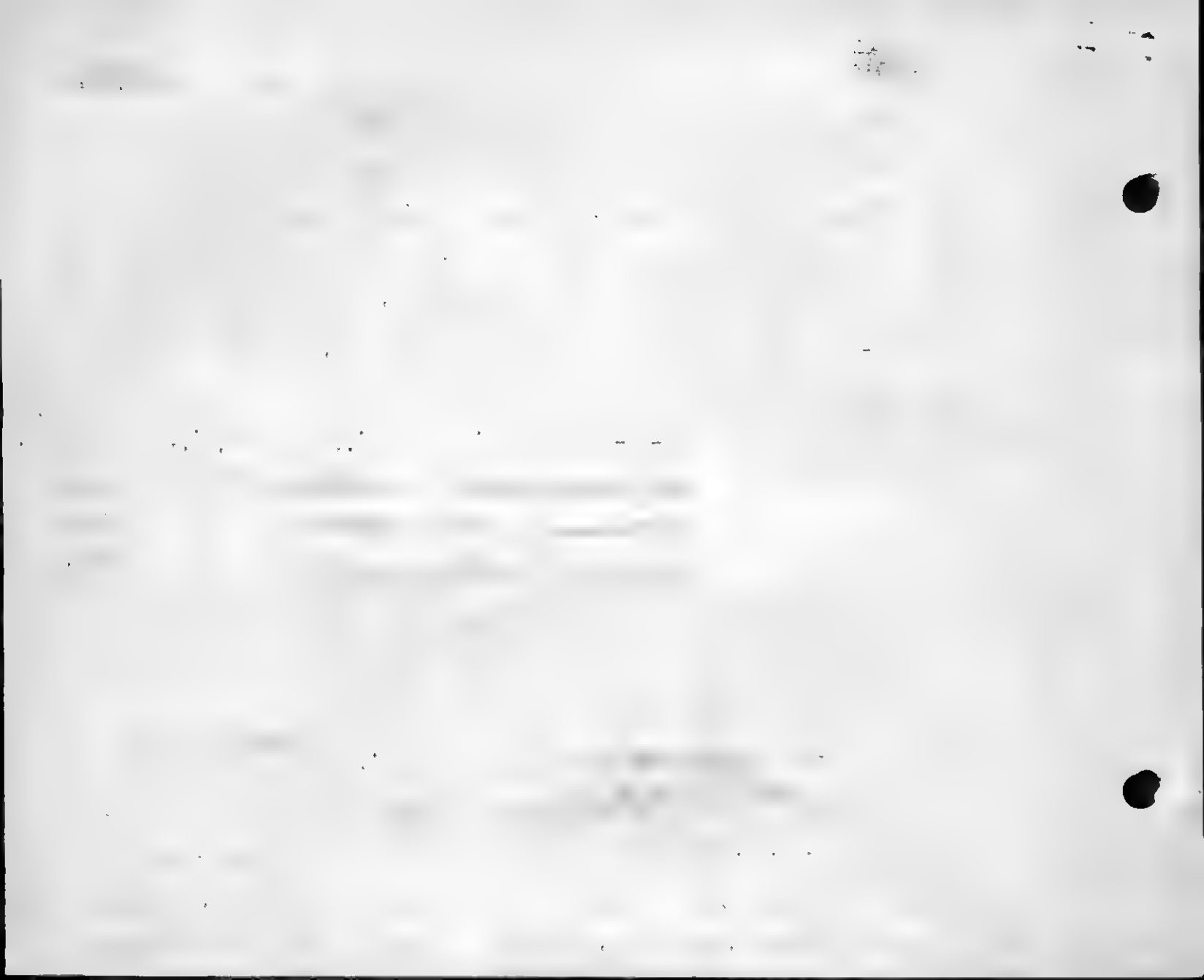


TO HOSPITAL ON ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04366 CERTIFICATE OF DEATH 04368

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 626 Hammond Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AVERY Middle LEE Last BOWDEN		4. DATE OF DEATH Month March Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1897
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 4 Days 16 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Baker		10b. KIND OF BUSINESS OR INDUSTRY Bread Company	
11. BIRTHPLACE (County & State, or foreign country) Whaylesville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lemuel Bowden		14. MOTHER'S MAIDEN NAME Annie Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-10-2112	
17. INFORMANT Mr. Thomas F. Bowden & Mrs. Sadie Bowden 306 Pryor Ave., Salisbury, Md.		Address (wife) Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct DUE TO (b) coronary thrombosis DUE TO (c) coronary atherosclerosis CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 hrs 3 hrs 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 1957 to March 21, 1967 , that (I) (we) last saw the deceased alive on March 20, 1967 , and that death occurred at 9:35M , from the causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED March 21, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. L. V. Sohler		22d. ADDRESS 303 East Street, Delmar, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 25, 1967	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR MAR 27 1967 25b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1-66

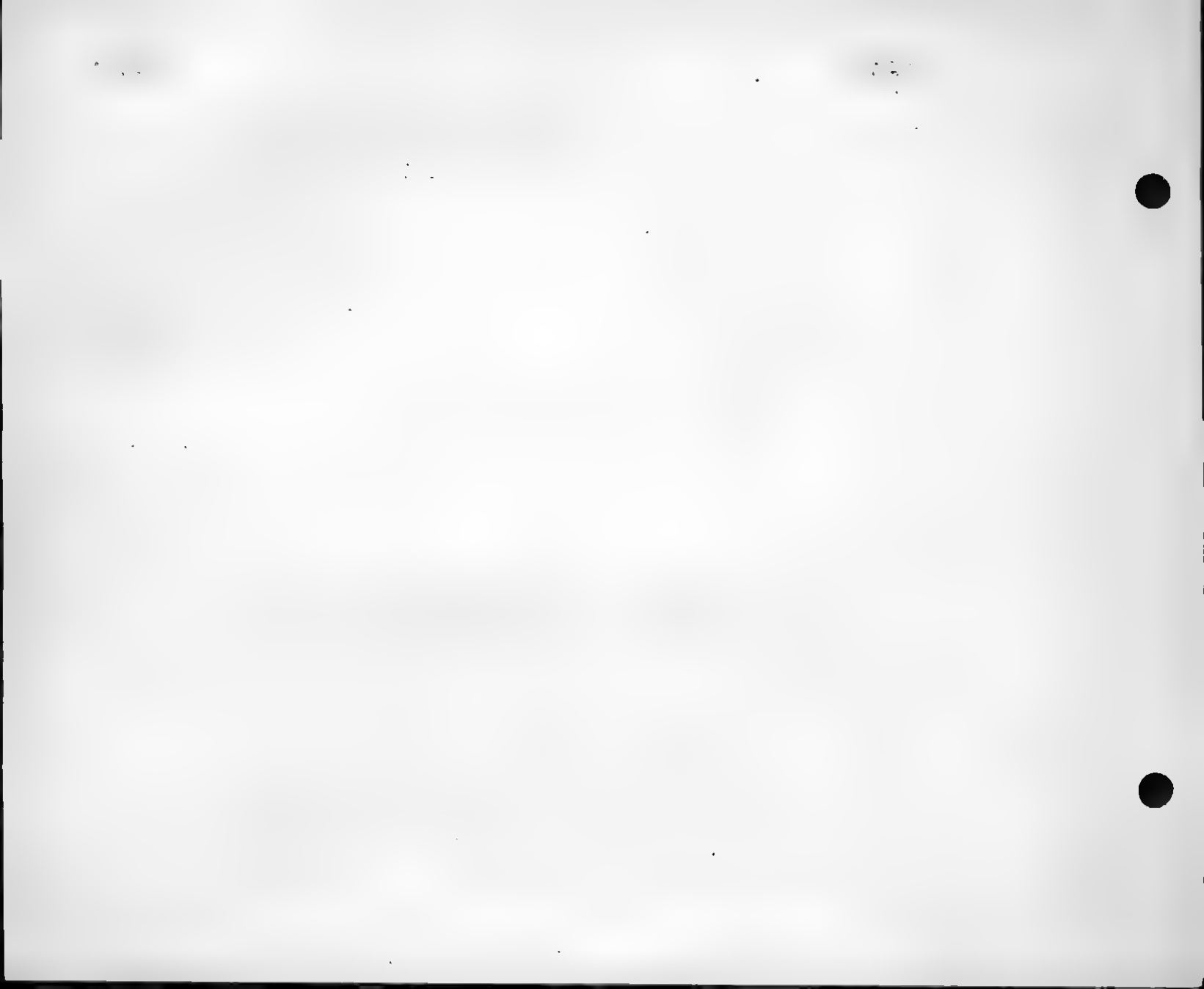
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04367

CERTIFICATE OF DEATH

04369

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>13 DAYS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First <u>LURANA</u> Middle <u>OWENS</u> Last <u>BRITTINGHAM</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>2</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1884</u>
9. AGE (In years (last birthday)) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Del. Sussex</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Owens</u>		14. MOTHER'S MAIDEN NAME <u>LAURA Willey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Mrs MARIA Betts Delmar, Md.</u>		Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arterio sclerotic cardiovascular disease</u> DUE TO (b) <u>Diabetes mellitis</u> DUE TO (c) <u>Diabetic gangrene, foot</u>			INTERVAL BETWEEN ONSET AND DEATH <u>20+ yrs</u> <u>20+ yrs</u> <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-18</u> , 19 <u>67</u> , to <u>3-2</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>3-2</u> , 19 <u>67</u> , and that death occurred at <u>4:50</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Kent Carney</u>		22b. DATE SIGNED <u>3-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENT CARNEY</u>		22d. ADDRESS <u>SALISBURY, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-6-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>GREENWOOD Del.</u>
24. FUNERAL DIRECTOR <u>Hill Funeral Home Salisbury, Md.</u> <u>Roman F. Baker</u>		25a. REC'D BY REGISTRAR <u>MAR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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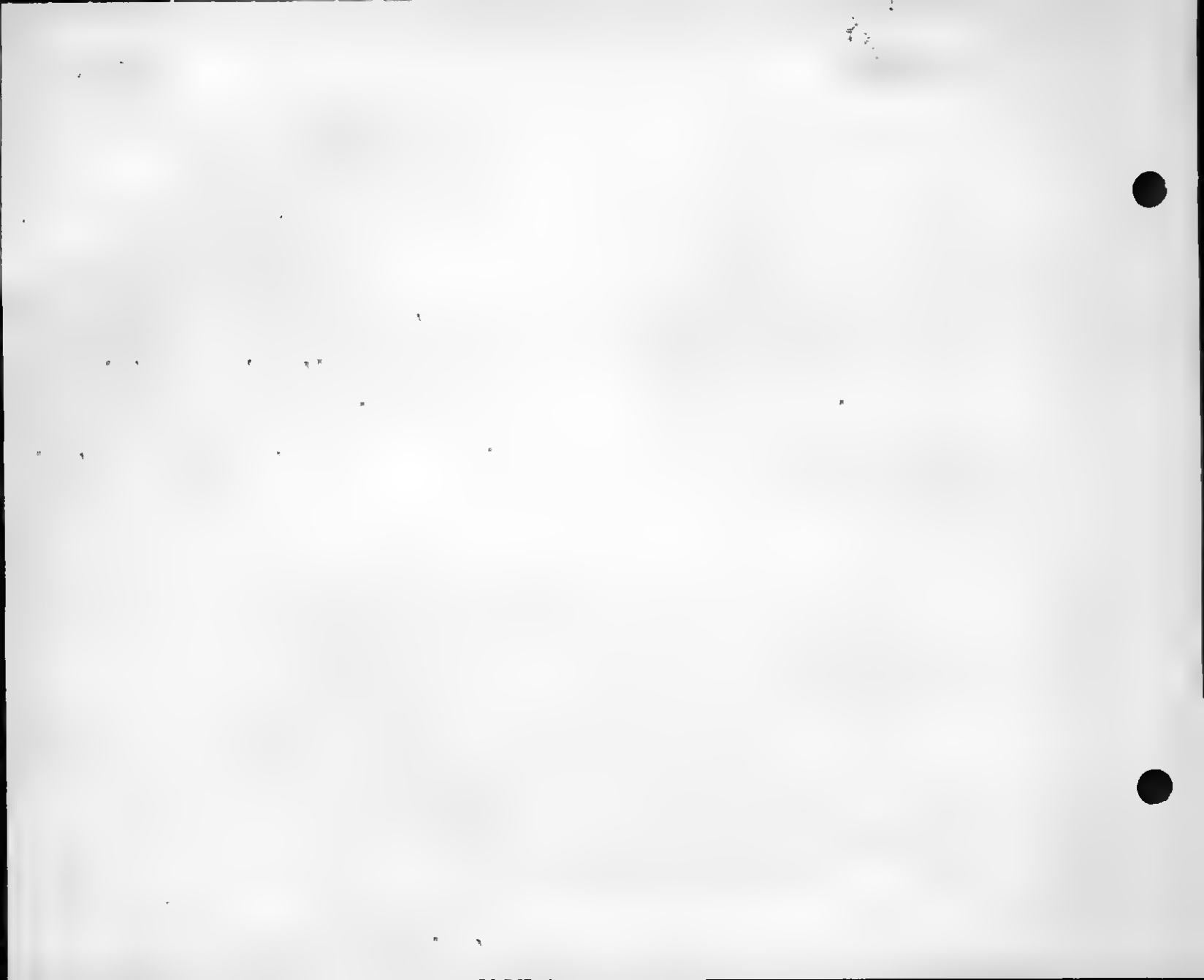
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04368

CERTIFICATE OF DEATH

04370

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Somerset Ave.	
3. NAME OF DECEASED (Type or print) George Elmer Brown		4. DATE OF DEATH Month March Day 28 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1891
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Internal Revenue Service		12. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.	
13. FATHER'S NAME George W. Brown		14. MOTHER'S MAIDEN NAME Ella A. Bounds	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Dorothy Brown, Princess Anne, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 163X IMMEDIATE CAUSE (a) Carcinoma of lung with metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 6 A.M. from causes and on the date stated above.			
22a. SIGNATURE Suband E. Hughes		22b. DATE SIGNED 3/28/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, or other disposition Burial	23b. DATE THEREOF 3/30/1967	23c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian	23d. LOCATION (City or Town) (County) (State) Princess Anne, Maryland
24. FUNERAL DIRECTOR James Seiman		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

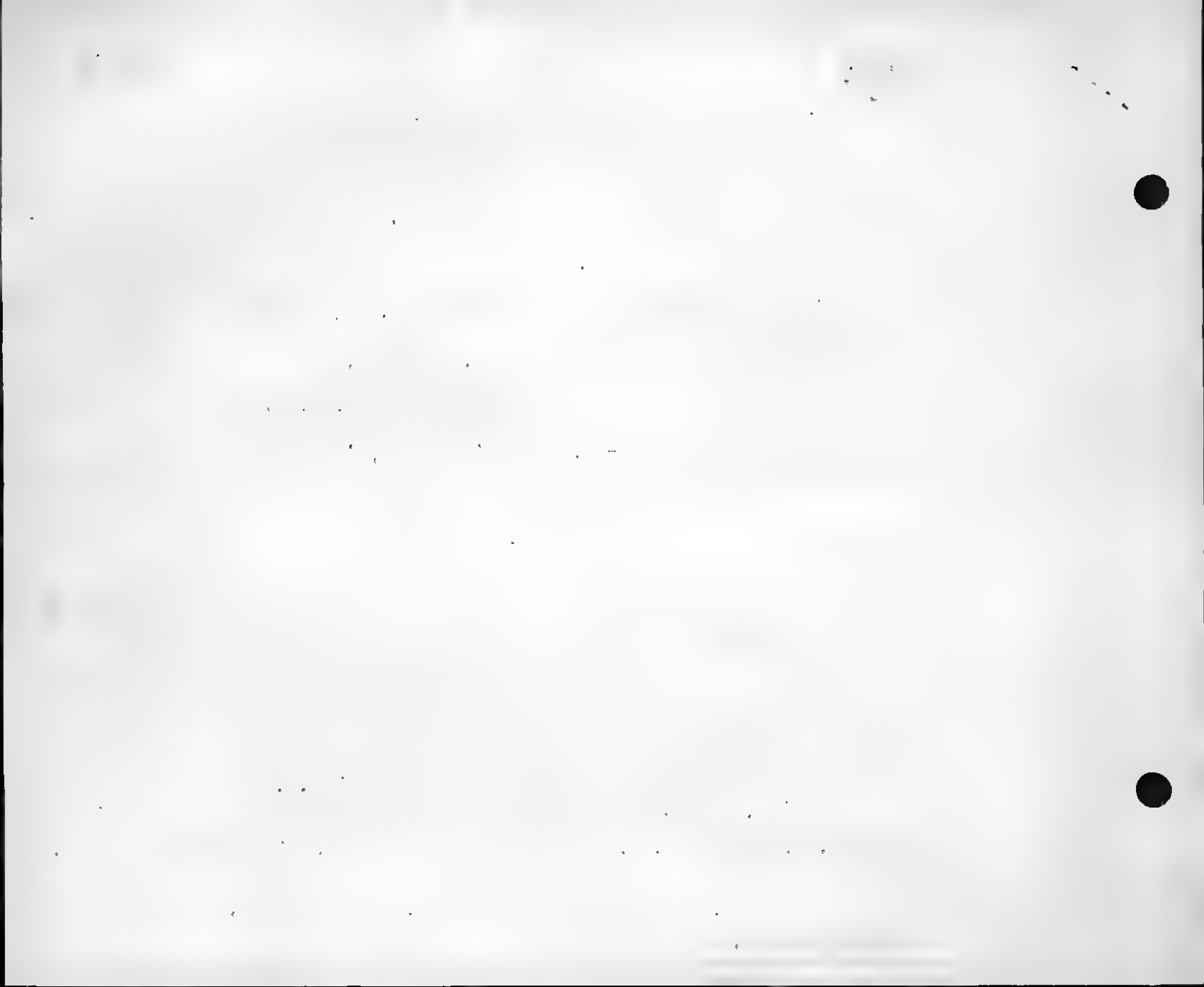
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04369

04371

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS 303 E. Locust Street	
3. NAME OF DECEASED (Type or print) First Norma Middle Mae Last Bunting		4. DATE OF DEATH Month March Day 16 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 24, 1887
9. AGE (In years lost birthday) 79 yrs		10. IF UNDER 1 YEAR Months 4 Days 22 Hours Min. 	
11a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		11b. KIND OF BUSINESS OR INDUSTRY W. Wheeling, Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lewis Steele	
14. MOTHER'S MAIDEN NAME Lillian Purdy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-52-8179		17. INFORMANT Mr. Bernard T. Bunting (Son) White Haven, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332A IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) Cerebral thrombosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 11 days 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 1/11 , 19 67 , to 3/16 , 19 67 , that (I) (we) last saw the deceased alive on 3/16 , 19 67 , and that death occurred at 4:35 P.M. , from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 3/17/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL (CREMATION, REMOVAL) (Specify) Burial	23b. DATE THEREOF March 20, 1967	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR MAR 20 1967	
25b. REGISTRAR'S SIGNATURE 		25c. REGISTRAR'S SIGNATURE 	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

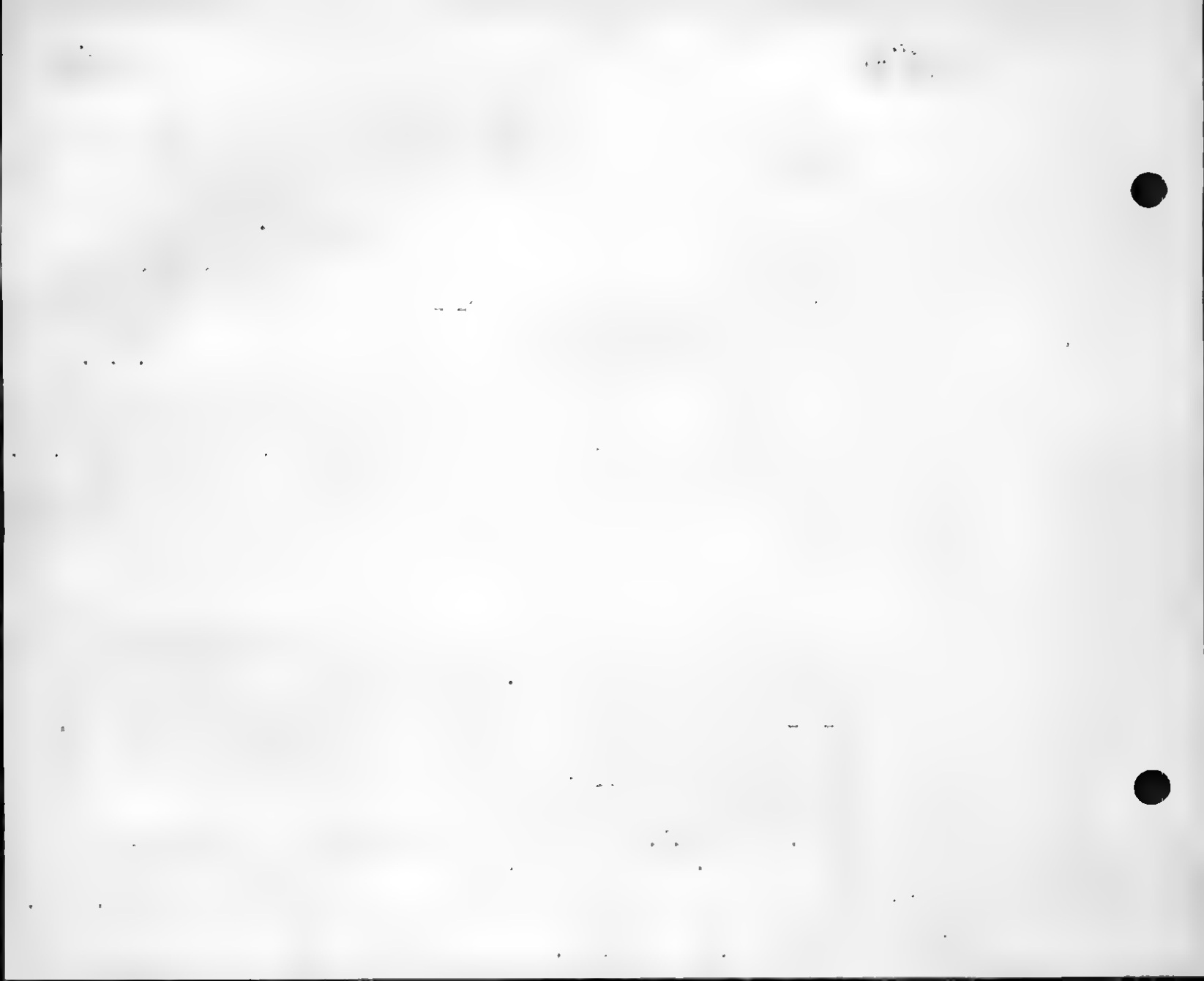
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04372

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a STATE Maryland b COUNTY Worcester		
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b 17 days	c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Pocomoke City		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital			d STREET ADDRESS 407 Walnut St.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last CAUSEY			4 DATE OF DEATH Month March Day 14 Year 1967		
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-9-1882	9 AGE (In years lost birthday) 85 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b KIND OF BUSINESS OR INDUSTRY Building	11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.
13 FATHER'S NAME -unknown-			14 MOTHER'S MAIDEN NAME -unknown-		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 214-12-6489	17 INFORMANT Mrs Lillie Causey, Pocomoke City, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH year
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) Fractured left hip					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) Fell at home.			
20c TIME OF INJURY Month, Day, Year Hour 7:30 pm 2-24-67 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, off building, etc.) Own home	20f (City or town) Pocomoke, Worcester, Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22 DATE SIGNED March 18, 1967	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) 409 Camden Ave., Salisbury, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 3-16-1967	23c NAME OF CEMETERY OR CREMATORY Bethany Methodist	23d LOCATION (City or Town) Pocomoke City	(County) Wor.	(State) Md.
24. FUNERAL DIRECTOR Robert H. Watson		ADDRESS Watson Funeral Home, Pocomoke, Md.		25a REC'D BY REGISTRAR MAR 21 1967	25b REGISTRAR'S SIGNATURE J. Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT

04371

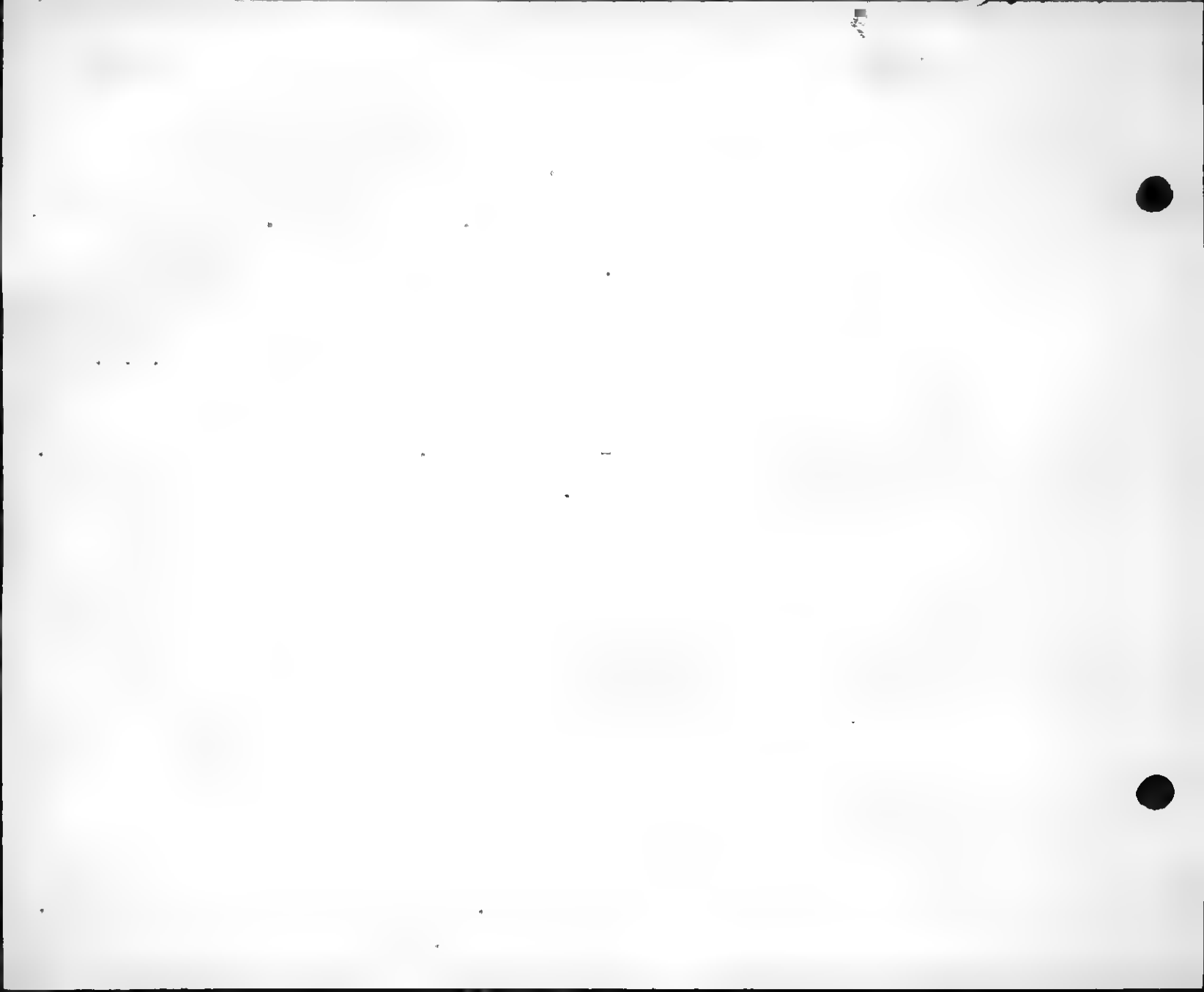
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04373

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Delaware b COUNTY Sussex ✓			
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b 4 hrs.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Selbyville			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d STREET ADDRESS E. Railroad Ave.		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Arthur A. Cephas				4 DATE OF DEATH Month 3 Day 26 Year 1967			
5 SEX male	6 COLOR OR RACE colored	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Mar. 4, 1913	9 AGE (In years last birthday) yrs 54	F UNDER 1 YEAR Months Days		I UNDER 24 HRS Hours Min
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b KIND OF BUSINESS OR INDUSTRY lumber		11 BIRTHPLACE (State or foreign country) New Jersey		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME William Hooper Cephas				14 MOTHER'S MAIDEN NAME Roxie Cephas			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 216-18-8914		17 INFORMANT Address Janie M. Cephas - Selbyville, Dela.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) gun shot wound left chest & abdominal DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							INTERVAL BETWEEN ONSET AND DEATH 5 hrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18) Shot 38 cal. pistol					
20c TIME OF INJURY Month Day Year 11-30 AM 3-26-67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Home		20f (City or town) (County) (State) Selbyville Del	
21 I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Ph. V. P. A. Insley		EXAMINER'S NAME (Type) Ph. V. P. A. Insley		22. DATE SIGNED 3-27-67		22. DATE SIGNED 3-27-67	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 3/30/1967		23c NAME OF CEMETERY OR CREMATORY Showell Cem.		23d LOCATION (City or Town) (County) (State) Showell, Worcester Md.	
24 FUNERAL DIRECTOR Richard T. Watson		ADDRESS Selbyville, Dela.		25a REC'D BY REGISTRAR DATE MAR 30 1967		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

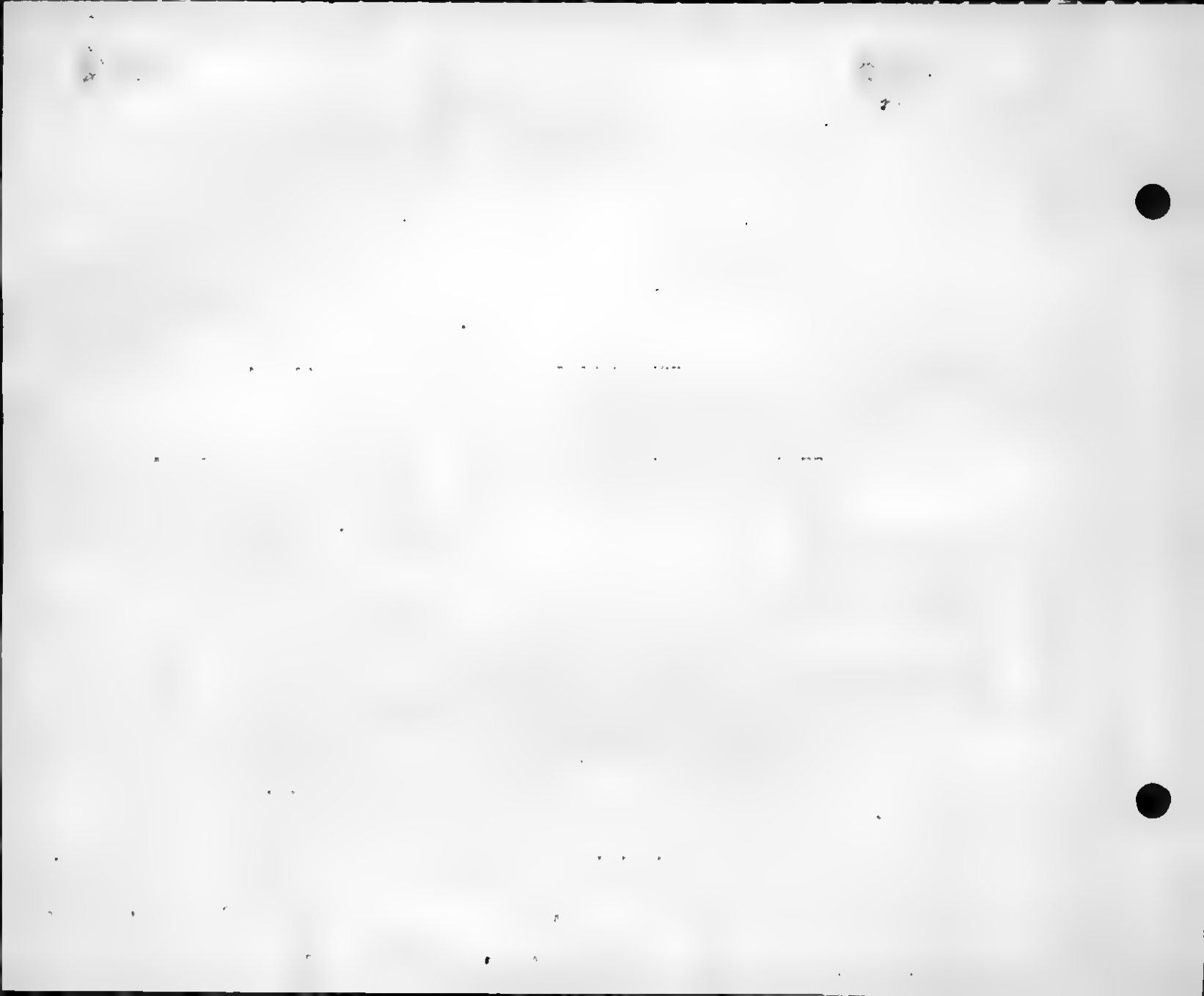
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04372

CERTIFICATE OF DEATH

04374

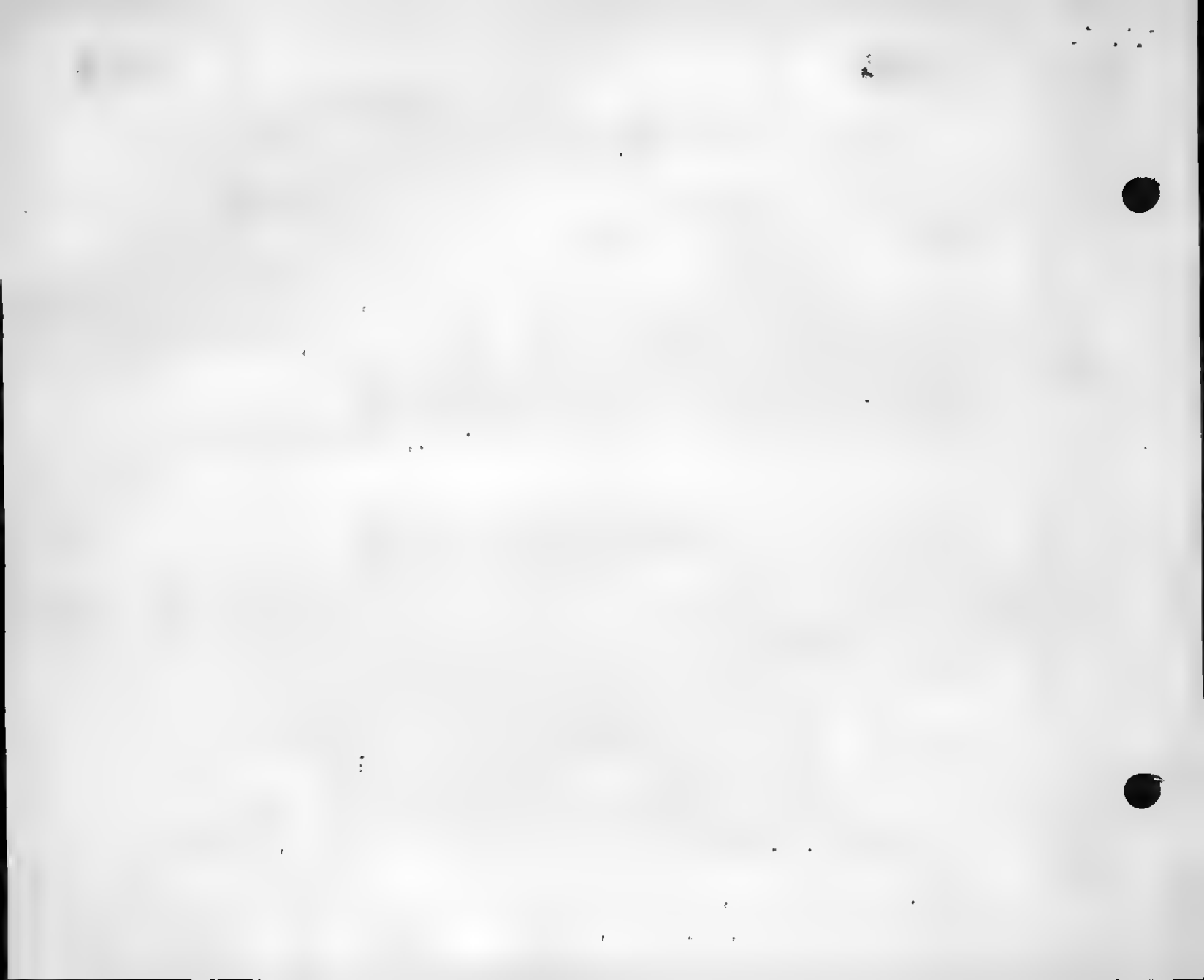
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 317 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital				d. STREET ADDRESS 606 Hubert Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maude Middle Eva Last Coleman				4. DATE OF DEATH Month March Day 23 Year 1967			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 6, 1900		9. AGE (In years lost birthday) 66 yrs	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Draper Keene				14. MOTHER'S MAIDEN NAME Mary Chester			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-6048		17. INFORMANT Walter Coleman		Address Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of rectum 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Arteriosclerotic cardiovascular disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/10 , 19 66 , to 3/23 , 19 67 , that (I) (we) last saw the deceased alive on 3/23 , 19 67 , and that death occurred at 11:40 A.M. , from causes and on the date stated above.							
22a. SIGNATURE <i>A. C. Mitchell</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 3/23/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M.D.				22d. ADDRESS Deer's Head Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/26/67		23c. NAME OF CEMETERY OR CREMATORY St. Peters		23d. LOCATION (City or Town) (County) (State) Meekins Neck Dor. Md.	
24. FUNERAL DIRECTOR <i>Frederick C. Delair</i>				ADDRESS Cambridge, Md.		25a. REC'D BY REGISTRAR MAR 27 1967	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
04373				04375									
1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Adm. in 1 D 3/5/67				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 330 Camden Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First HAZEL Middle VIRGINIA Last COLLINS				4. DATE OF DEATH Month March Day 17 Year 1967									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 19, 1909		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 28		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Somerset County, Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert W. Heath				14. MOTHER'S MAIDEN NAME Mollie Messick									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 		17. INFORMANT Address Mrs. Clinton Massey (Sister) Main St., Willards, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY + PERITONEAL METASTASIS 176X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) CARCINOMA - BREAST - RT. DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH 3 mos 3 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from JAN - 1967 to 17 Mar, 1967 , that (I) (we) last saw the deceased alive on 17 Mar 1967 , and that death occurred at 10:30 AM , from the causes and on the date stated above.													
22a. SIGNATURE Dr. H. Gray Reeves				22b. DATE SIGNED March 21/1967									
22c. PHYSICIAN'S NAME (Type) Dr. H. Gray Reeves				22d. ADDRESS Medical Center, Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF March 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR MAR 23 1967				25b. REGISTRAR'S SIGNATURE J. Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

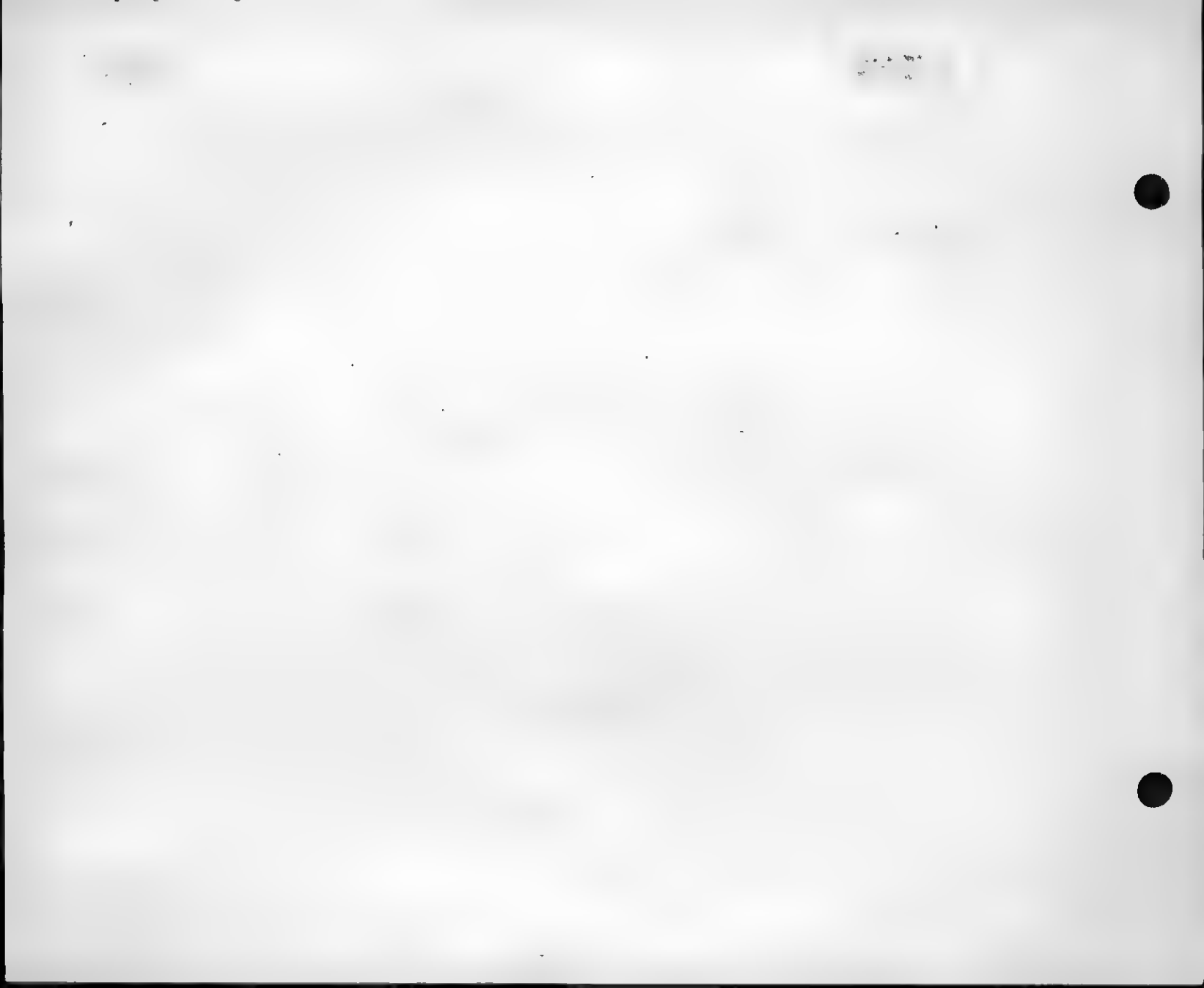
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04374

CERTIFICATE OF DEATH

04376

1. PLACE OF DEATH a. COUNTY Wicomico		b. COUNTY Wicomico	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 726 Westover Drive	
3. NAME OF DECEASED (Type or print) Laura S. Collins		4. DATE OF DEATH Month MARCH Day 18 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-28-1909
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 18 Days 18 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		11. BIRTHPLACE (County & State, or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Lee	
14. MOTHER'S MAIDEN NAME Louana Brown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT HYBERNIA FREEMAN Address 124 N. LARK AVE Youngstown Ohio	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CIPX DUE TO Respiratory Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Empyema DUE TO Broncho pleural Fistulae			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Lung - Rt Upper Lobectomy			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 12:30 M, from causes and on the date stated above.			
22a. SIGNATURE Ronald D. Snyder, M.D.		22b. DATE SIGNED 3/19/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-22-67	23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State) SNOW HILL Wicomico Md.
24. FUNERAL DIRECTOR Louisa B. Jolley - Jersey Rd. Rt 2 Salisbury, Md.		25a. REC'D BY REGISTRAR MAR 31 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04375

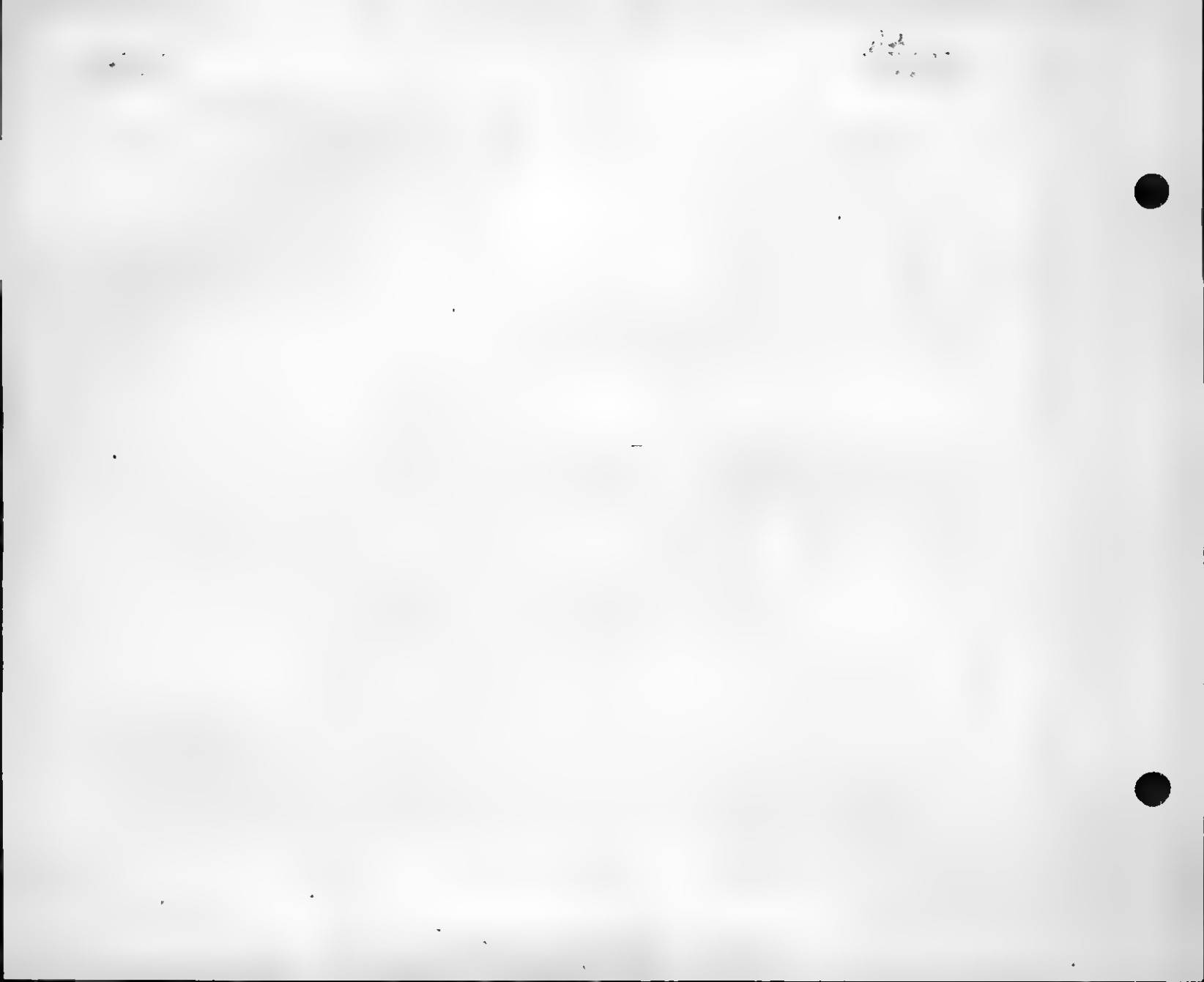
CERTIFICATE OF DEATH

04377

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Willards	
3. NAME OF DECEASED (Type or print) First ROSA Middle ALICE Last Cooper		4. DATE OF DEATH Month March Day 30 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17 1897
9. AGE (In years lost birthday) 74 yrs		10. IF UNDER 1 YEAR Months 11 Days 13	11. IF UNDER 24 HRS. Hours 11 Min. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Taylor	
14. MOTHER'S MAIDEN NAME Lavina Lewis		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XX XX	
16. SOCIAL SECURITY NO 212-16-1412		17. INFORMANT Lillian Downs Address Willards, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) SSIX DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH App 10 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Deceased Mother			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-30 , 19 67 , to 3-30 , 19 67 , that (I) (we) last saw the deceased alive on 3-30 , 19 67 , and that death occurred at 7:38 M, from causes and on the date stated above.			
22a. SIGNATURE James H. Cooper M.D.		22b. DATE SIGNED	22c. PHYSICIAN'S NAME (Type) James H. Cooper
22d. ADDRESS Willards, Md.		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/2/67	23c. NAME OF CEMETERY OR CREMATORY Cooper	23d. LOCATION (City or Town) (County) (State) Willards Md.
24. FUNERAL DIRECTOR Lester M. Halley		24b. ADDRESS Salisbury, Md.	25a. REC'D BY REGISTRAR APR 4 1967
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME (Type) Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04376

CERTIFICATE OF DEATH

04378

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>10 Yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sp. Mill Pr. Sani.</u>						d. STREET ADDRESS <u>311 N. Blvd.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ROGER WILSON DISHARON</u>				4. DATE OF DEATH Month Day Year <u>3 2 19 67</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Nov. 24, 1897</u>		9. AGE (In years last birthday) yrs <u>69</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Branch Manager</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Life Insurance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Worester, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry W. Disharoon</u>						14. MOTHER'S MAIDEN NAME <u>Ollie Coulbourn</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO <u>229-01-8974</u>		17. INFORMANT Address <u>Mrs. Helen Nock Disharoon sec 2</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary vascular renal disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , to <u>3-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>31</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Philip A. Insley</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-3-1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Philip A. Insley</u>						22d. ADDRESS <u>Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>					
24. FUNERAL DIRECTOR <u>Hill Funeral Home Salisbury, Maryland</u>						25a. REC'D BY REGISTRAR DATE <u>MAR 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, under any event, within 72 hours after death.

Norman T. Becker



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

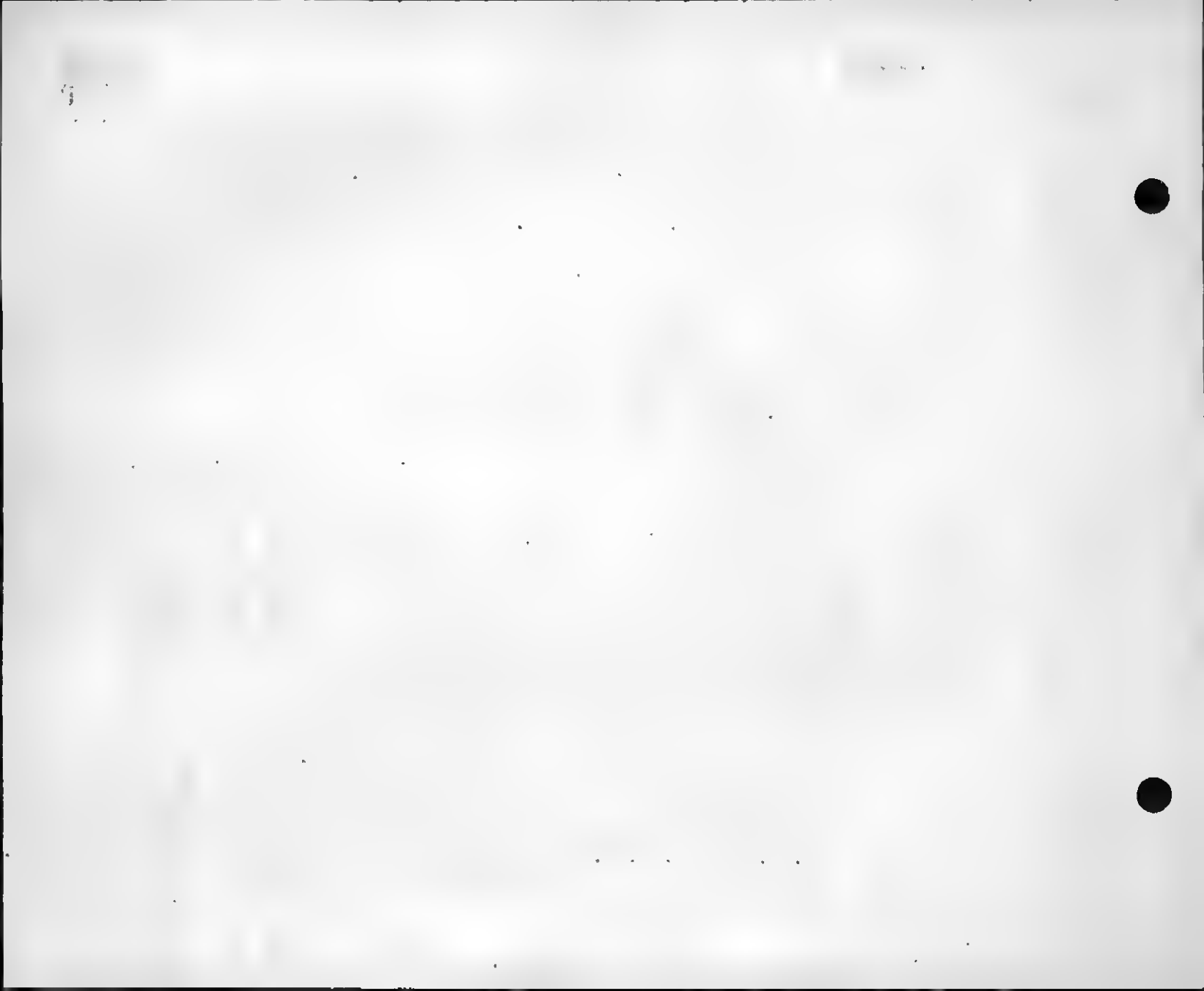
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04377

CERTIFICATE OF DEATH

04379

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2,464 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whaleyville		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ethel Middle M. Last Downs		4. DATE OF DEATH Month March Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1890
9. AGE (In years last birthday) 76 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harbison El Lynch		14. MOTHER'S MAIDEN NAME Laggie Hudson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) XX		16. SOCIAL SECURITY NO XX	
17. INFORMANT George Downs		Address Whaleyville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia 441X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple rheumatoid arthritis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/8 , 19 60 to 3/8 , 19 67 , that (I) (we) last saw the deceased alive on 3/8 , 19 67 , and that death occurred at 5:05 M, from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 3/9/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF 3/11/67	23c. NAME OF CEMETERY OR CREMATORY Roxana	23d. LOCATION (City or Town) (County) (State) Roxana, Delaware
24. FUNERAL DIRECTOR W. H. Selby		25. REC'D BY REGISTRAR MAR 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S ADDRESS Selbyville, Del.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04378

Item #2a,b,c & d info. taken from birth cert.

CERTIFICATE OF DEATH

04380

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Rt. #3, Box 389A	
3. NAME OF DECEASED (Type or print) BABY DUNCAN		4. DATE OF DEATH Month MARCH Day 7 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-67
9. AGE (In years lost birthday) 1 yrs.		10. IF UNDER 1 YEAR Months 1 Days 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wicomico		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Adolphus Douglas DUNCAN		14. MOTHER'S MAIDEN NAME Audrey Spence	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMANT Emily Spence		Address Berlin Md, R.F.D #3-Box 389A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Immaturity DUE TO (b) Premature Labor DUE TO (c) Placental Separation		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9:15 A M, from causes and on the date stated above.			
22a. SIGNATURE R. L. Baker M.D.		ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-9-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Chapel	23d. LOCATION (City or Town) (County) (State) NEWARK Wor. Md.
24. FUNERAL DIRECTOR Loretta B Jolley - Salisbury, Md.		25a. REC'D BY REGISTRAR MAR 16 1967	25b. REGISTRAR SIGNATURE [Signature]



7-1

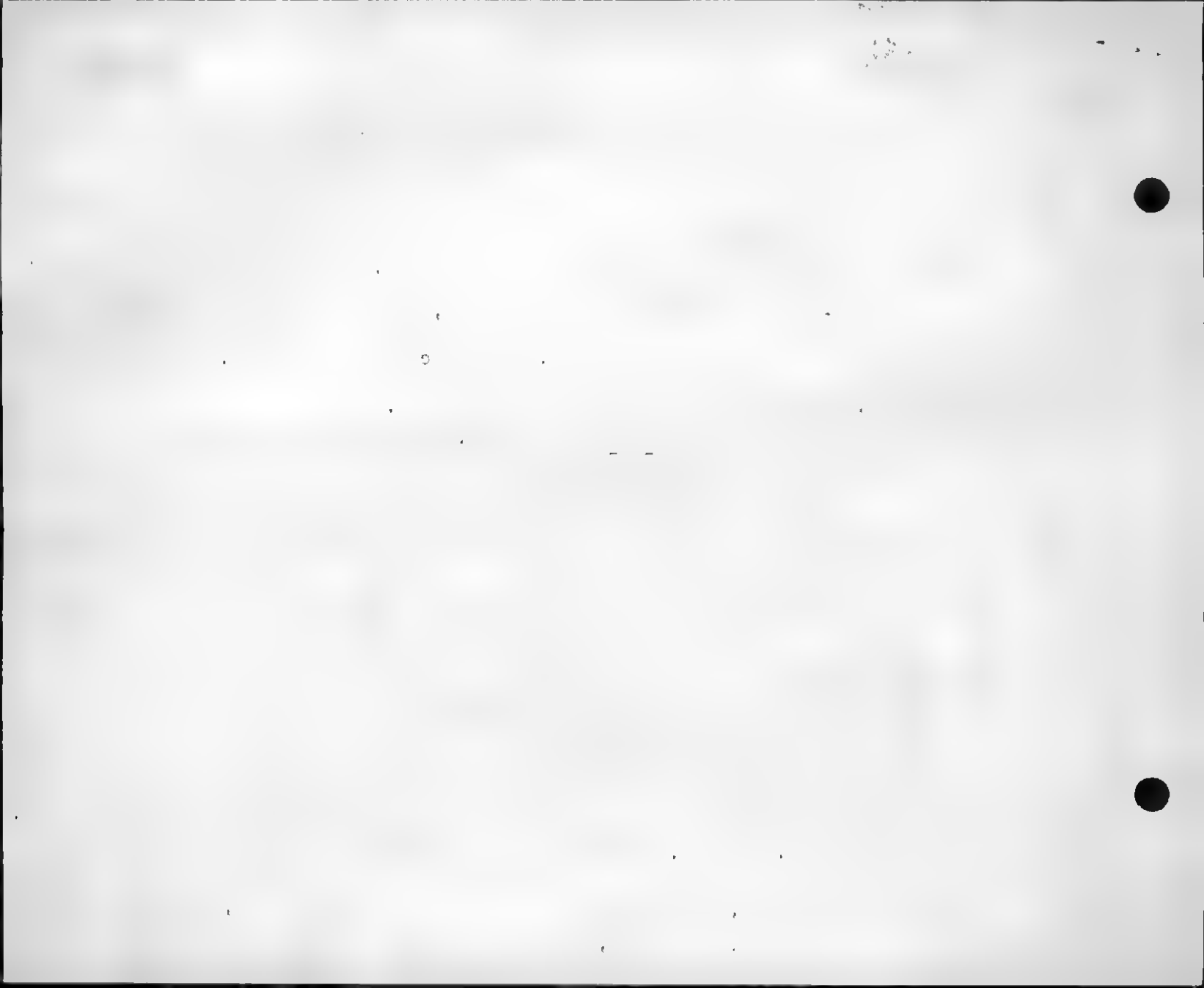
04379

CERTIFICATE OF DEATH

04381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>607 Monroe Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cecil</u> Middle <u>JOHN</u> Last <u>Dykes, SR.</u>				4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 11, 1911</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tester</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pump Co.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Worcester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles H. Dykes</u>				14. MOTHER'S MAIDEN NAME <u>Lula V. Davis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222-07-6263</u>		17. INFORMANT Address <u>Mrs. Maude Pruitt Dykes (Wife)</u> <u>607 Monroe Street, Salisbury, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Hypertensive syndrome</u> DUE TO (b) <u>Acute myocardial infarction</u> DUE TO (c) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>9 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-23, 1967</u> to <u>3-31, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-31, 1967</u> , and that death occurred at <u>7:42 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James L. Clifford</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 1 / 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. James L. Clifford</u>				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 2, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>APR 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

04380

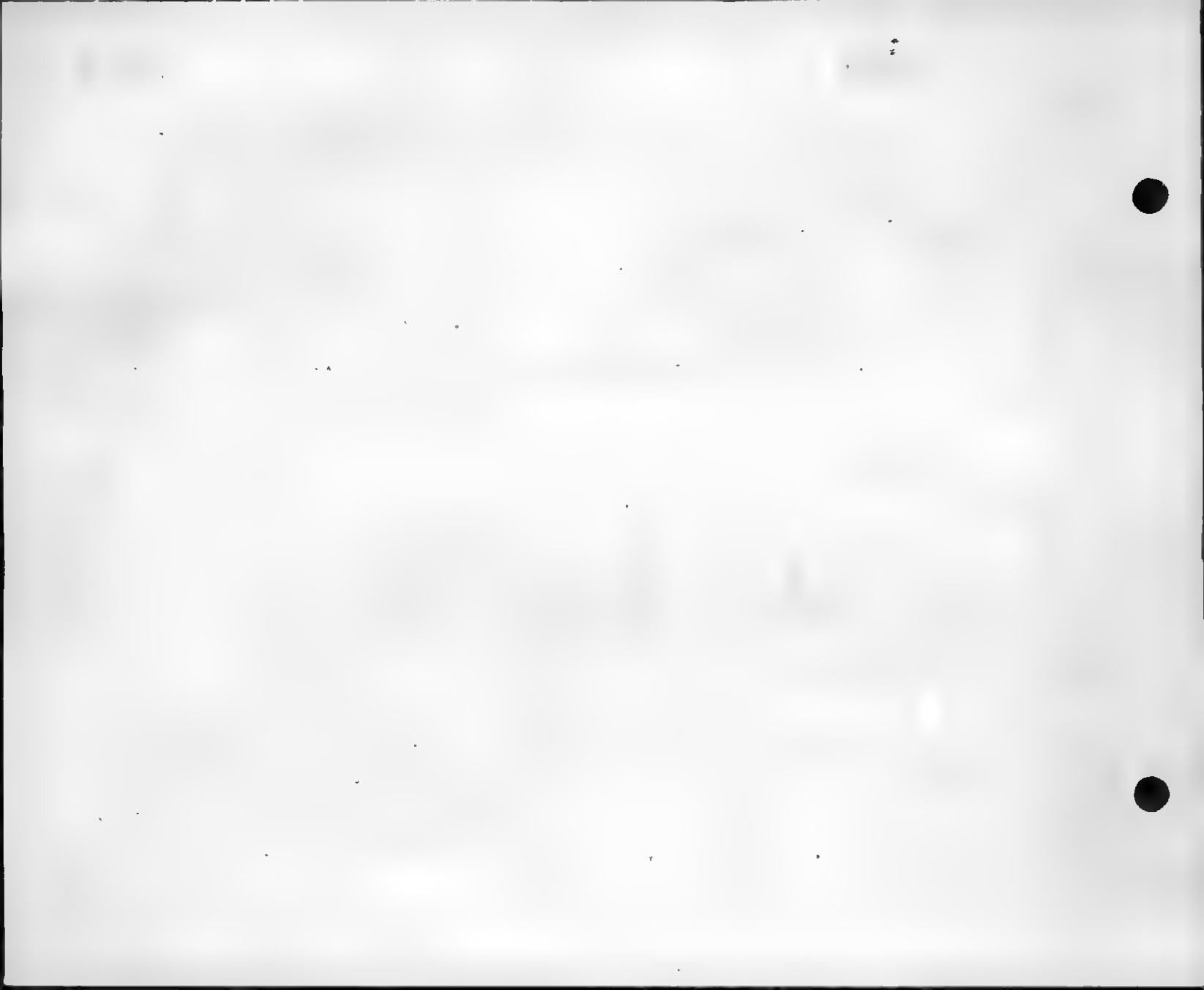
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04382

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in 1b since 12/31/66 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Berlin	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		d STREET ADDRESS R # 1, Box 90 e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First JOHN Middle JOURNEY Last ELLIOTT		4. DATE OF DEATH Month March Day 25 Year 19 67	
5 SEX M	6 COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Oct. 13, 1897
9. AGE (In years lost birthday) 69 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman	11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland
10b. KIND OF BUSINESS OR INDUSTRY -----		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME James Elliott		14. MOTHER'S MAIDEN NAME Celia Messick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-9691-A	
17. INFORMANT Records of Pine Bluff Hospital		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY. 4201 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/31, 1966 , to 3/25, 1967 , that (I) (we) last saw the deceased alive on 3/25, 1967 , and that death occurred at 2:10 M, from causes and on the date stated above.			
22a. SIGNATURE E.P. Ritchings		22b. DATE SIGNED 3/26/67	
22c. PHYSICIAN'S NAME (Type) E.P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital	
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/28/67	23c. NAME OF CEMETERY OR CREMATORY SUNNYRIDGE	23d LOCATION (City or Town) (County) (State) CRISTFIELD MD R.F.D
24 FUNERAL DIRECTOR Anna A. Burbage Berlin Md		25a REC'D BY REGISTRAR MAR 30 1967	25b REGISTRAR'S SIGNATURE James Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

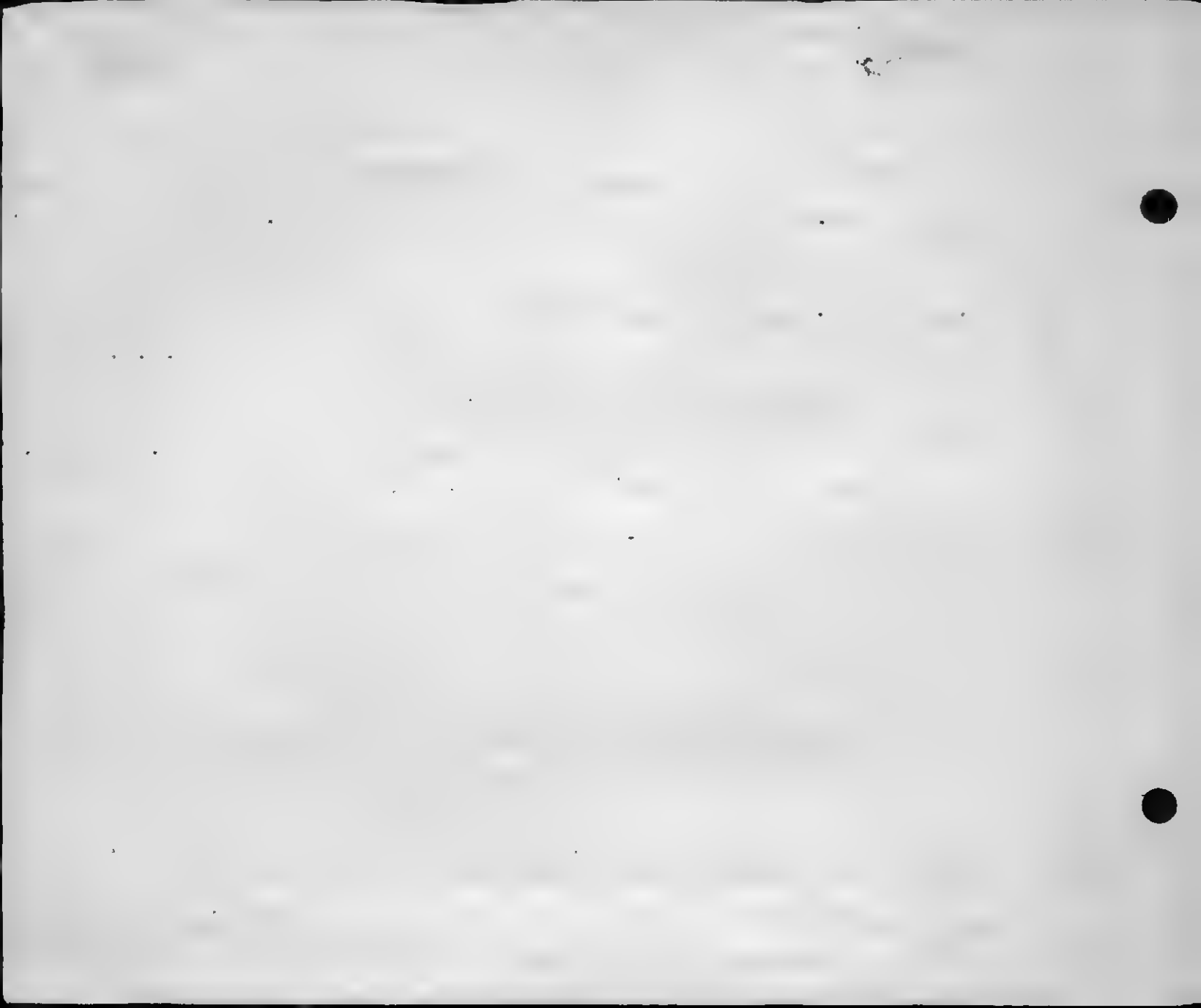
CERTIFICATE OF DEATH

04381

04383

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fitzwater St. 683</u>				d. STREET ADDRESS <u>683 Fitzwater St.</u>			
3. NAME OF DECEASED (Type or print) <u>Charles Fletcher</u>				4. DATE OF DEATH <u>March 6 1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/26/1895</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Emma Fletcher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mae Frazier 683 Fitzwater St. Salis-Md.</u>				Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) <u>(I) (M.D.)</u> attended the deceased from <u>1/16/63</u> to <u>3/4/67</u> , that (I) <u>(M.D.)</u> saw the deceased alive on <u>3/4/67</u> , and that death occurred at <u>2 P</u> M., from the causes and on the date stated above.							19. <u>3/4/67</u>
22a. SIGNATURE <u>Ivory U. Sully, Jr., MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr., MD</u>				22d. ADDRESS <u>P. O. Box 126, Berlin, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/4/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>				ADDRESS <u>Salis Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 14 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>							



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 5-63

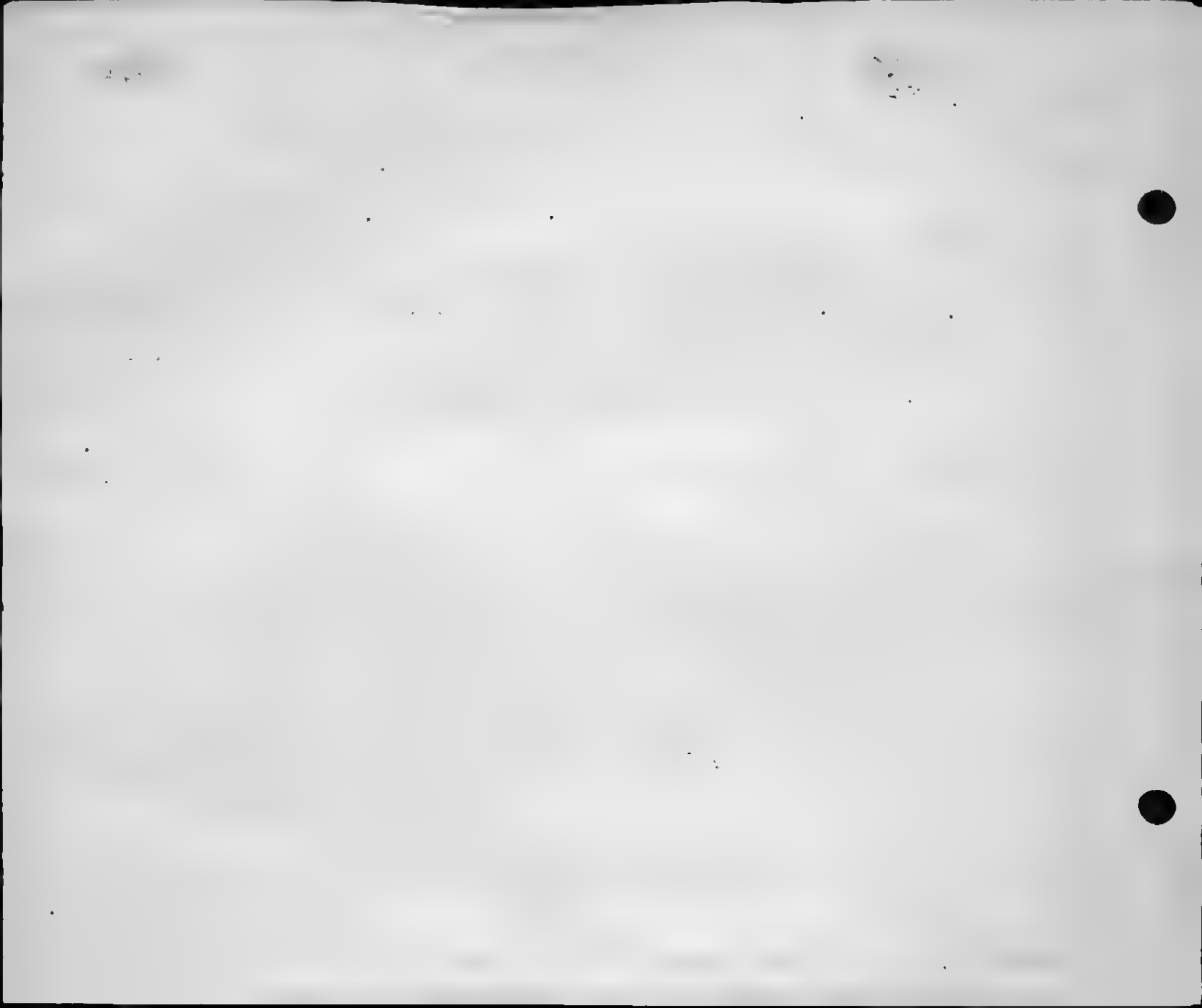
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04382		Item #2d Film #G307 4/0/07 pc		04384	
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wicomico Nursing Home, Booth St.</u>		d. STREET ADDRESS <u>Booth St. 729 Richmond Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cecile Frazier</u>		4. DATE OF DEATH <u>March 22 1967</u>		5. SEX <u>F</u>	
6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1900</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHP. <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Hyder Kves</u>	
14. MOTHER'S MAIDEN NAME <u>Hattie Branington</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Vernie Frazier No 3 Nockmois Ave.</u>	
17. INFORMANT <u>Vernie Frazier</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Hypertensive C-V-R Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) <u>Delmar</u>		20g. (County) <u>Del.</u>		20h. (State) <u>Del.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 22 1967</u> to <u>Mar 22 1967</u> , that (I) (we) last saw the deceased alive on <u>Mar 22 1967</u> and that death occurred at <u>11:00</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>William W. Gray</u>		22b. DATE SIGNED <u>Mar 22 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>William W. Gray</u>	
22d. ADDRESS <u>Salisbury</u>		22e. REC'D BY REGISTRAR <u>Charles Judge</u>		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/24/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nemo</u>	
23d. LOCATION (City, town or county) <u>Delmar</u>		23e. (State) <u>Del.</u>		23f. (Country) <u>U.S.A.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton S. Stewart</u>		24a. ADDRESS <u>Salisbury</u>		24b. REC'D BY REGISTRAR <u>Charles Judge</u>	
24c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		24d. DATE <u>Mar 30 1967</u>		24e. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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14

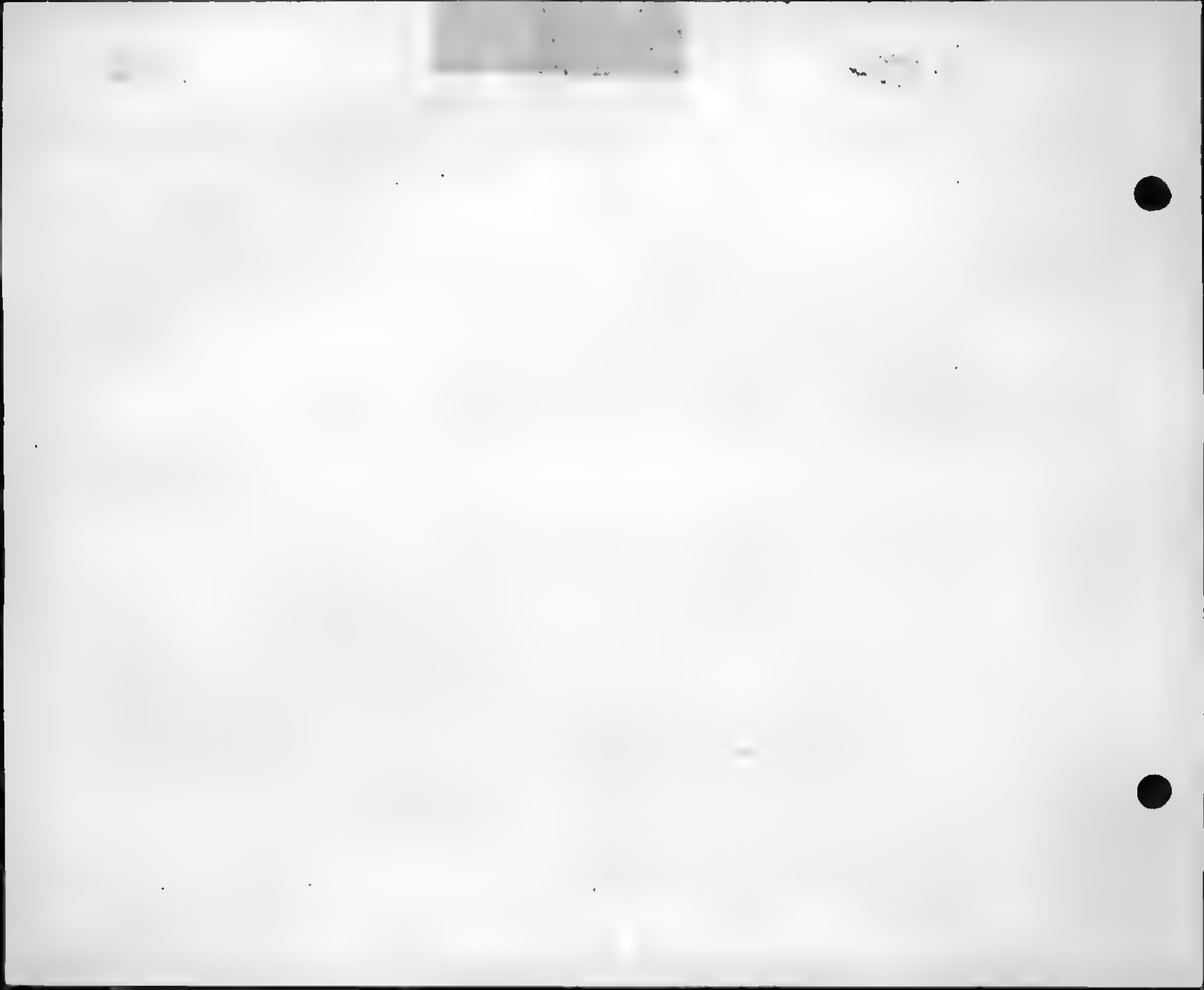
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04383

CERTIFICATE OF DEATH

04385

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 22 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 111 E. Eighth St.	
3. NAME OF DECEASED (Type or print) SARAH PATE GARDNER		DATE OF DEATH MARCH 6 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1898, 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Parkley, Va.	
13. FATHER'S NAME Edward C. Pate		14. MOTHER'S MAIDEN NAME Etta Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. INFORMANT Elyabeth Pate Address Salisbury Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute antro-lateral myocardial infarction DUE TO (b) Coronary atherosclerosis DUE TO (c) Coronary atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 48 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Previous antro-lateral myocardial infarction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-22-66 , to 3-6-67 , that (I) (we) last saw the deceased alive on 3-6-67 , and that death occurred at 6:35 M, from causes and on the date stated above.			
22a. SIGNATURE James L. Gifford M.D.		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) James L. Gifford		22d. ADDRESS Medical Center Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-8-67	23c. NAME OF CEMETERY OR CREMATORY Parkley	23d. LOCATION (City or Town) (County) (State) Parkley, Acco, Va.
24. FUNERAL DIRECTOR J. Richard Johnson		25a. REC'D BY REGISTRAR MAR 10 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04384

CERTIFICATE OF DEATH

04386

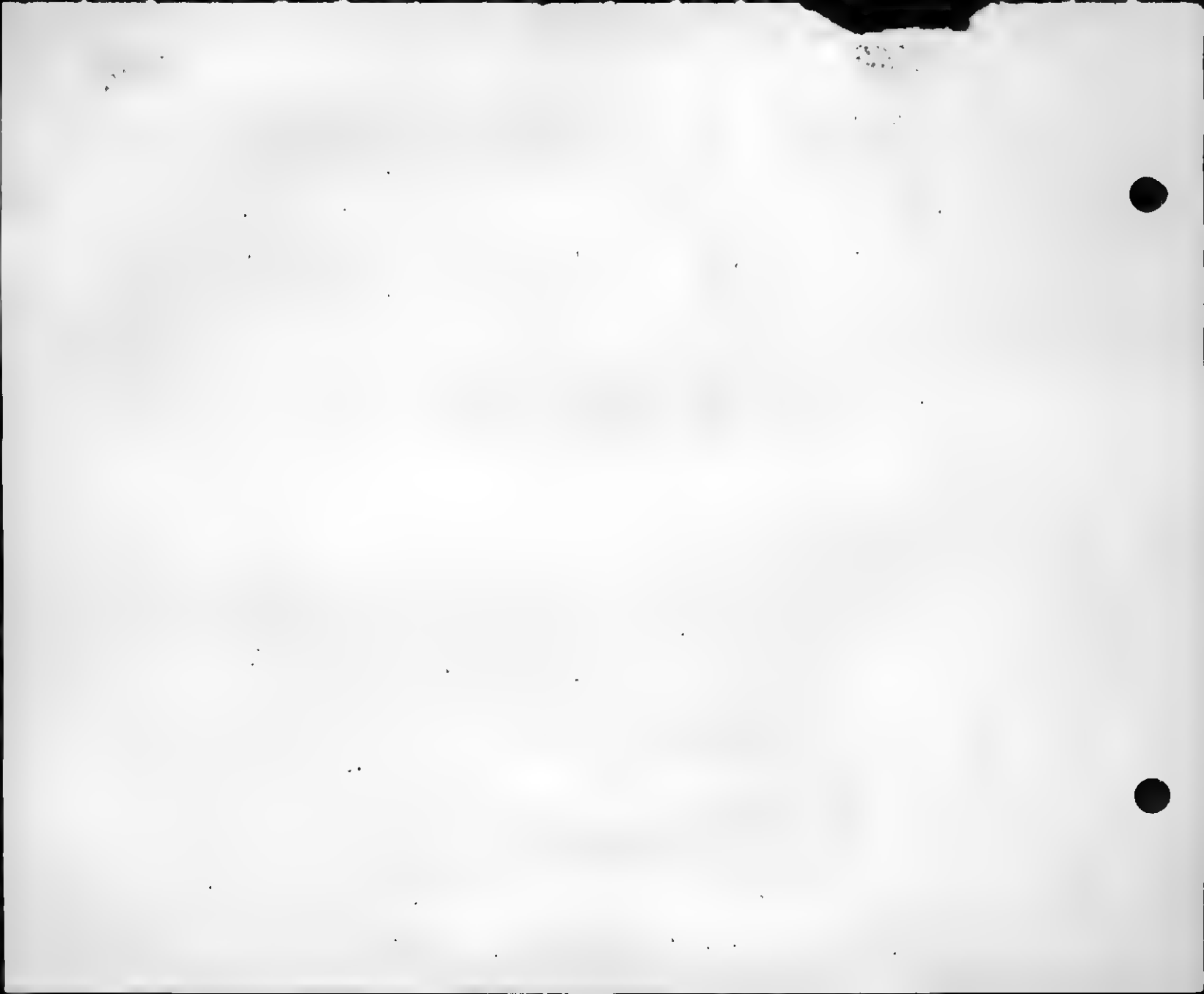
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b Salisbury d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City d. STREET ADDRESS GOLF COURSE RD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CAROLINE F Gilbert		4. DATE OF DEATH Month Day Year March 4 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) FLORIDA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mr. HAROLD GILBERT		Address Ocean City, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, Heart Failure 4:00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-28, 1967 to 7-4, 1967 that (I) (we) last saw the deceased alive on 7-4, 1967 and that death occurred at 6:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Charles Judge		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) Charles Judge		22d. ADDRESS Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/7/67	23c. NAME OF CEMETERY OR CREMATORY RIVERSIDE	23d. LOCATION (City or Town) (County) (State) BERLIN WOOD BLDG MD
24. FUNERAL DIRECTOR Anna R. Burbage		25. REC'D BY REGISTRAR MAR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04385					04387					
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b <u>5 mos.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WICOMICO NURSING HOME</u>					d. STREET ADDRESS <u>1014 SMITH ST</u>					
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>BUNSTEIN</u> Last <u>Gilmore</u>			4. DATE OF DEATH Month <u>March</u> Day <u>31</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/11/1896</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RET. NURSE</u>			11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK STATE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>ALEXANDER GILMORE</u>					14. MOTHER'S MAIDEN NAME <u>ESTHER BUNSTEIN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>DAVID J. GILMORE SEE #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary failure</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis with cerebral involvement</u> DUE TO (c) <u>10 yrs</u>								INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hip Fracture</u> <u>10/6/66</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at home Springs Hill Nursing home</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>Oct 10 1966</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Springs Hill home</u>		20f. (City or town) (County) (State) <u>Salisbury Wic. Md</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> , 19 <u>66</u> , to <u>MAR 31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAR 31</u> , 19 <u>67</u> , and that death occurred at <u>2:35 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>M. D. Stephanides</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. D. STEPHANIDES</u>					22d. ADDRESS <u>111 DAVIS ST, SALISBURY, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>4/4/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>G.A.R. CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>SUMMIT HILL, PENN.</u>			
24. FUNERAL DIRECTOR <u>Franklin B. Hill</u>					25a. REC'D BY REGISTRAR <u>shlibary</u>		25b. REGISTRAR'S SIGNATURE <u>gcharles judge</u>			
DATE <u>APR 4 1967</u>										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 1/66

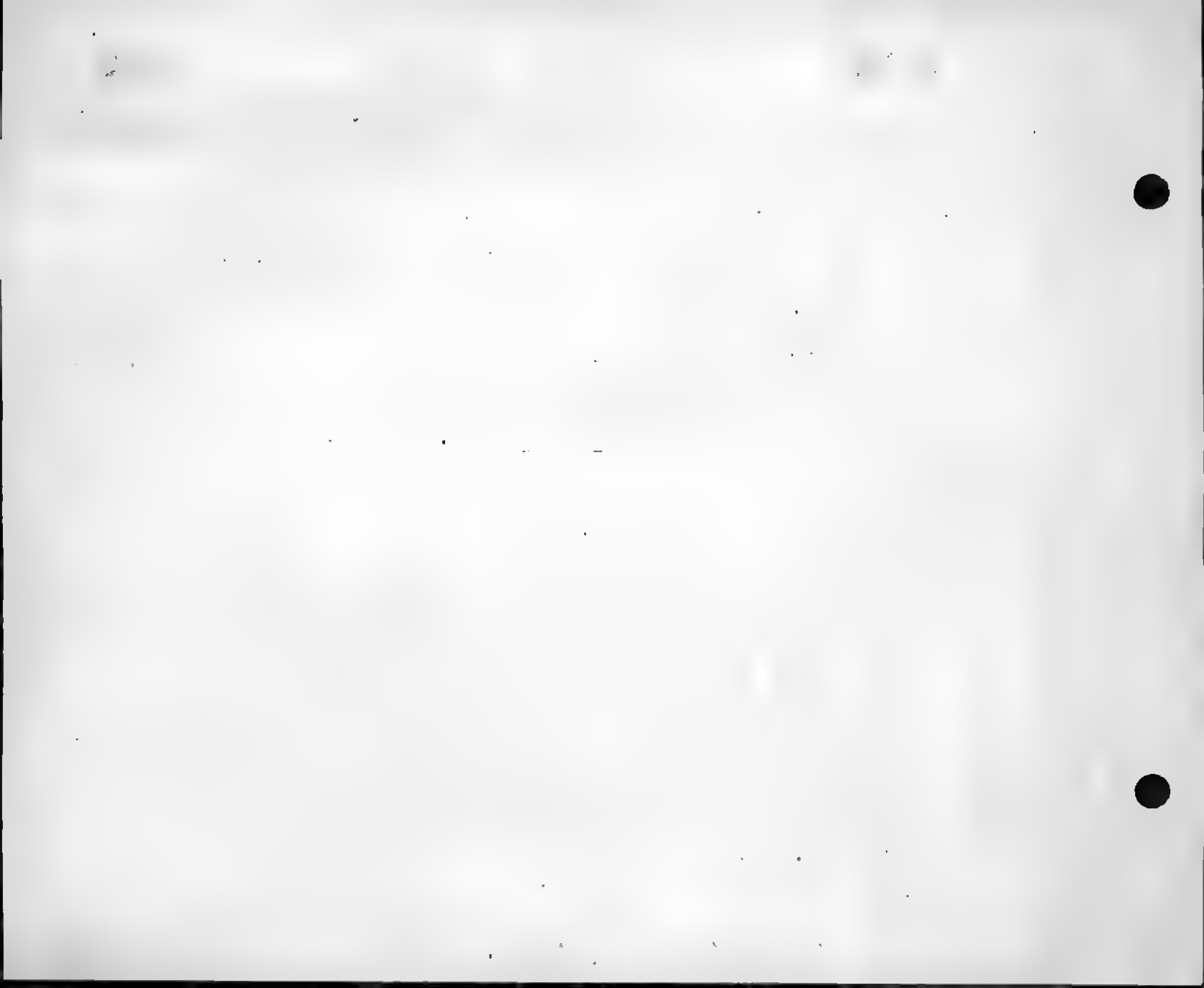
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04386

CERTIFICATE OF DEATH

04388

1 PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY WICOMICO c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Route No. 3	
3 NAME OF DECEASED (Type or print) ALEXANDER EDWARD GREEN		4 DATE OF DEATH Month MARCH Day 18 Year 1967	
5 SEX MALE	6 COLOR OR RACE Cauc.	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 19, 1896
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (County & State, or foreign country) B.A. Suriname Dutch Guina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexandria Edward Green		14. MOTHER'S MAIDEN NAME Sperling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 579-03-2519-A	
17. INFORMANT Mrs. Owen J. Ricker		Address 6529 N. 29th St. Arlington, Va.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Embolism DUE TO (c) Arthritis			INTERVAL BETWEEN ONSET AND DEATH 3 days 5720
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 3/10 , 19 67 , to 3/18 , 19 67 , that (2) (we) last saw the deceased alive on 3/18 , 19 67 , and that death occurred at 10 A.M. from causes and on the date stated above.			
22a. SIGNATURE Wm. B. Smith		22b. DATE SIGNED 3/18/67	
22c. PHYSICIAN'S NAME (Type) Wm. B. Smith		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL OR CREMATION Burial	23b. DATE THEREOF 3/21/67	23c. NAME OF CEMETERY OR CREMATORY National Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Falls Church, Virginia
24. FUNERAL DIRECTOR Arlington Funeral Home		25a. REC'D BY REGISTRAR DMAR 22 1967	
Address 3901 N. Fairfax Arlington, Va.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04387

CERTIFICATE OF DEATH

04389

1 PLACE OF DEATH a. COUNTY WICOMICO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b COUNTY WICOMICO	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c LENGTH OF STAY IN 1b 1 day	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ocean City
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PENINSULA GEN. HOSPITAL		d. STREET ADDRESS PACIFIC AVE.	
3 NAME OF DECEASED (Type or print) EDWARD RUSSELL GREENE		4. DATE OF DEATH Month MARCH Day 24 Year 1967	
5 SEX MALE	6 COLOR OR RACE WHITE	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891
9. AGE (In years lost birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GREENE		14. MOTHER'S MAIDEN NAME NELLIE BROOKS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT E.R. GREENE JR.		Address OCEAN CITY, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm DUE TO (b) Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-24 , 19 67 , to 3-24 , 19 67 that (I) (we) last saw the deceased alive on 3-24 , 19 67 , and that death occurred at 3:24 M, from causes and on the date stated above.			
22a. SIGNATURE Edward K. Carney		22b. DATE SIGNED 3-28-67	
22c. PHYSICIAN'S NAME (Type) EDWARD K. CARNEY		22d. ADDRESS MEDICAL CENTER, SALISBURY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Type and date) BURIAL	23b. DATE THEREOF 3/26/1967	23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY	23d. LOCATION (City or Town) (County) (State) SALISBURY, MARYLAND
24. FUNERAL DIRECTOR Dr. C. M. ...		25a. REC'D BY REGISTRAR DATE 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

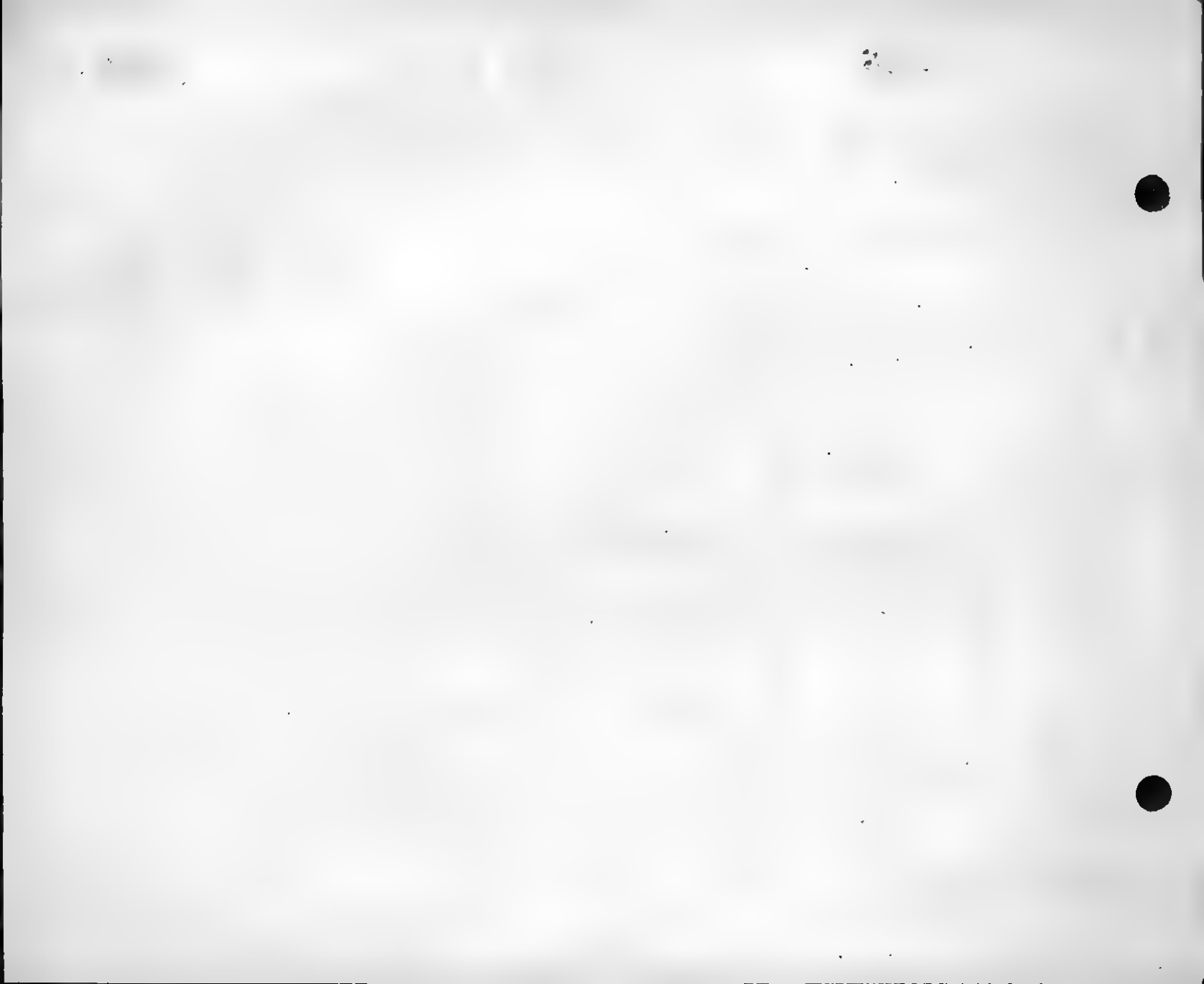
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04388

CERTIFICATE OF DEATH

04390

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R.F.D.	
3 NAME OF DECEASED (Type or print) First Middle Last ISAAC THOMAS GRIFFIN		4. DATE OF DEATH Month Day Year MARCH 31 19 67	
5 SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26 1891
9 AGE (In years last birthday) 75 yrs.		10. US. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR	
10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11 BIRTHPLACE (County & State, or foreign country) BERLIN MD	
12 CIT ZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME WILLIAM EDWARD GRIFFIN	
14. MOTHER'S MAIDEN NAME ROSEANN TIMMONS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 120-12-1819		17. INFORMANT Address MRS. I.T. GRIFFIN BERLIN MD RFD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 446X Anemia DUE TO (b) Nephrosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH One month	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease, Arteriosclerosis Obliterans			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mar. 25, 19 67, to Mar. 31, 19 67	
20f. (City or town) (County) (State) BERLIN MD		21. I certify that (I) (this hospital) attended the deceased from Mar. 25, 19 67 , to Mar. 31, 19 67 , that (I) (we) last saw the deceased alive on Mar. 31, 19 67 , and that death occurred at 4:05 A.M. from causes and on the date stated above.	
22a. SIGNATURE Stanley Silmore		22b. DATE SIGNED APR 4 1967	
22c. PHYSICIAN'S NAME (Type) Anna A. Burbage		22d. ADDRESS Berlin md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/2/67	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR. MD	
24. FUNERAL DIRECTOR Anna A. Burbage		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04389

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04391

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN b Salisbury	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		e STREET ADDRESS 623 Ridge Road	
3 NAME OF DECEASED (Type or print) First STANLEY Middle L. Last HALL		4 DATE OF DEATH Month March Day 29 Year 1967	
5 SEX Male	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-26-1888
9 AGE (in years lost birthday) 78 yrs		10 UNDER 1 YEAR Months 7 Days 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b KIND OF BUSINESS OR INDUSTRY Business Man	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Frank Hall		14 MOTHER'S MAIDEN NAME Ociea Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv ice)		16 SOCIAL SECURITY NO. 218-05-3214	
17 INFORMANT Mrs. Juanita Anderson		Address 623 Ridge Road Salisbury, Md	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerotic heart disease DUE TO (c) years			INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Hamcide <input type="checkbox"/> , Indetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED March 30, 1967	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF April 1, 1967	23c NAME OF CEMETERY OR CREMATORY Grotons	23d LOCATION (City or Town) (County) (State) Hallwood Va
24 FUNERAL DIRECTOR Lilliston Funeral Home, Accomac, Virginia		25a REC'D BY, REGISTER APR 4 1967	

1. 10. 1948

2. 11. 1948

3. 12. 1948

4. 1. 1949

5. 2. 1949

6. 3. 1949

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

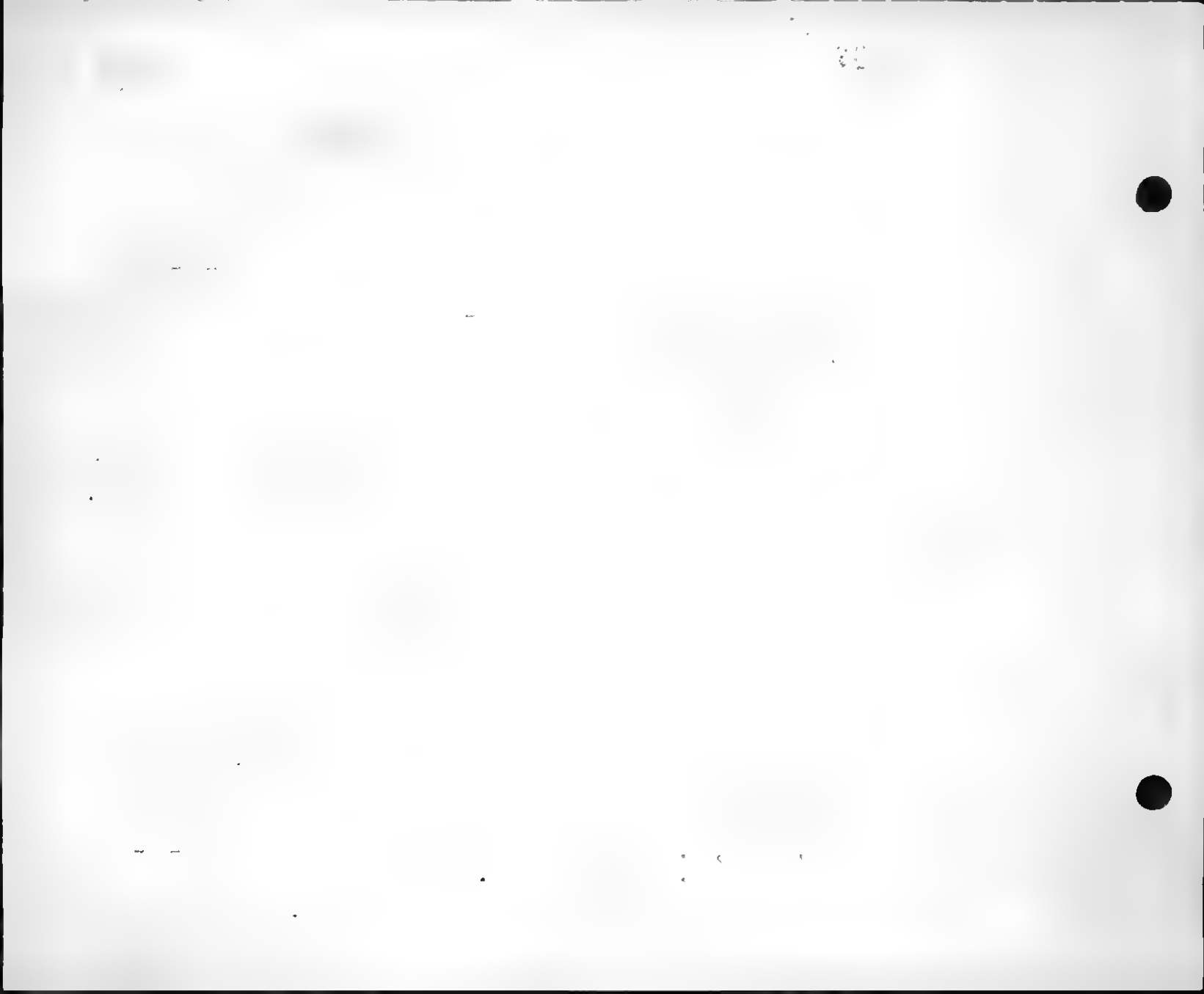
04390

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04392

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND			2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE Maryland b COUNTY Wicomico		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ty Zs Kin		c LENGTH OF STAY IN 1b 2 yrs		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ty Zs Kin	
d NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to, give street address)			d STREET ADDRESS		
3. NAME OF DECEASED (Type or print) Samuel Harris			4 DATE OF DEATH Month 3 Day 19 Year 67		
5 SEX M	6 COLOR OR RACE C	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-25-1911	9 AGE (In years last birthday) 55 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Georgia	
13 FATHER'S NAME Esaw Harris			14 MOTHER'S MAIDEN NAME Frances Taylor		
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 259-40-6113		17 INFORMANT Ida Mae G. Kat August 2, 67 Address Seclusion	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 pm		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 3-20-67			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		23a NAME OF CEMETERY OR CREMATORY Lincolnton, Ga.			
23b DATE INTERMENT 3/25/67		23c NAME OF CEMETERY OR CREMATORY New York Cem.			
23d LOCATION (City or town) (County) (State) Lincolnton, Ga.		25a REC'D BY REGISTRAR MAR 27 1967		25b REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR Charles Judge, BIV 316, Md.					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

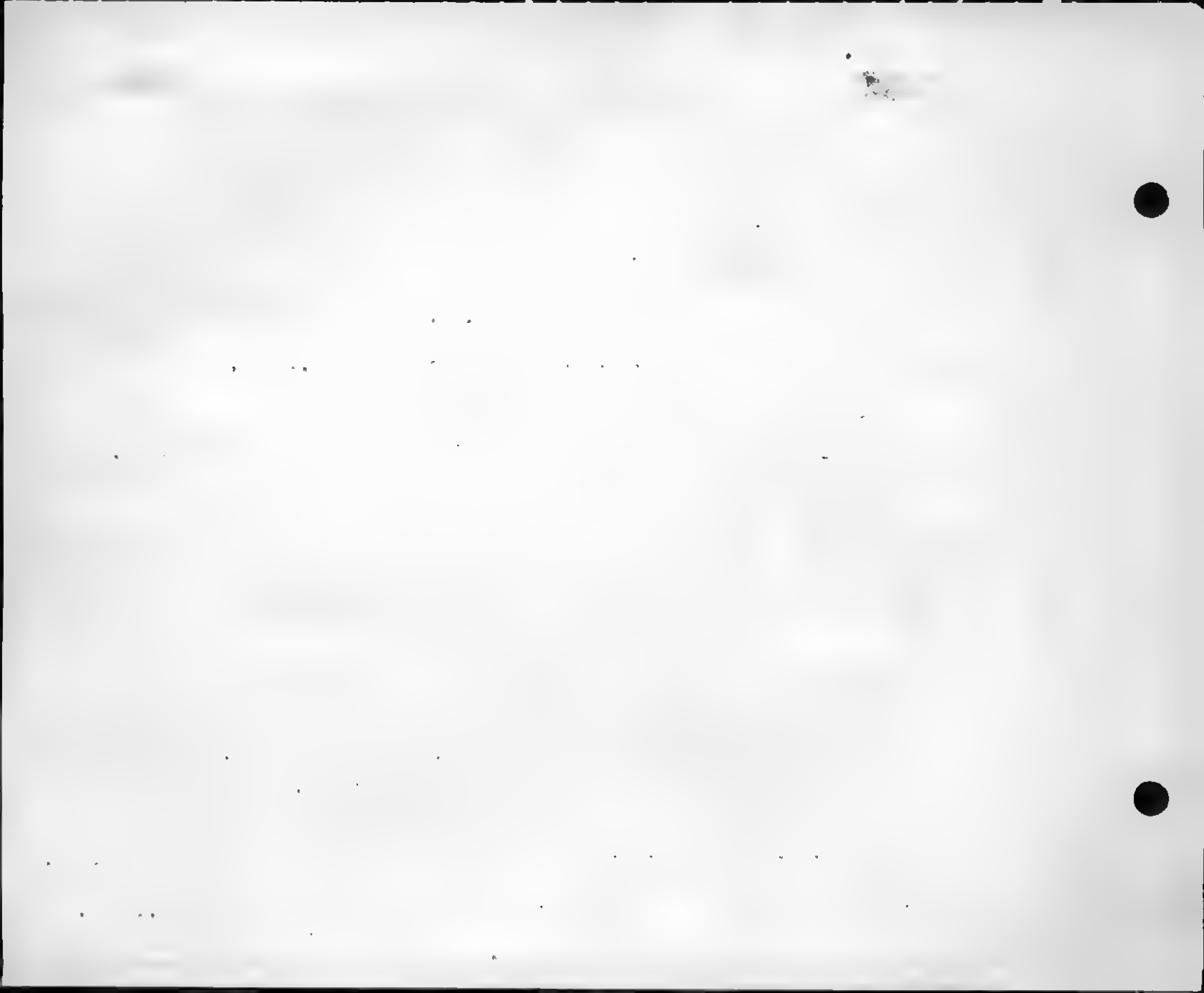
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04391

04393

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 397 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS 808 Phillips Street	
3. NAME OF DECEASED (Type or print) First Hattie Last Bishop Hughes		4. DATE OF DEATH Month March Day 19 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1900
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 3 Days 0 Hours 0 Min 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Dorchester Co., Md.	
13. FATHER'S NAME John Waters		14. MOTHER'S MAIDEN NAME Bertha Ennalls	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Lillie Johnson		Address Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Chronic pyelonephritis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Diabetes mellitus PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia			INTERVAL BETWEEN ONSET AND DEATH 3 months Years Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 4:20 P.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 15, 19 66 , to Mar. 19, 1967 , that (I) (we) last saw the deceased alive on March 19 19 67 , and that death occurred at 4:20 P. M. from causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve, M. D.		22b. DATE SIGNED 3/20/67	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/23/67	23c. NAME OF CEMETERY OR CREMATORY Meekins Neck	23d. LOCATION (City or Town) (County) (State) Dorchester Co., Md.
24. FUNERAL DIRECTOR John C. Delane		25. RECD BY REGISTRAR Charles Judge	
ADDRESS Cambridge, Md.		DATE MAR 21 1967	



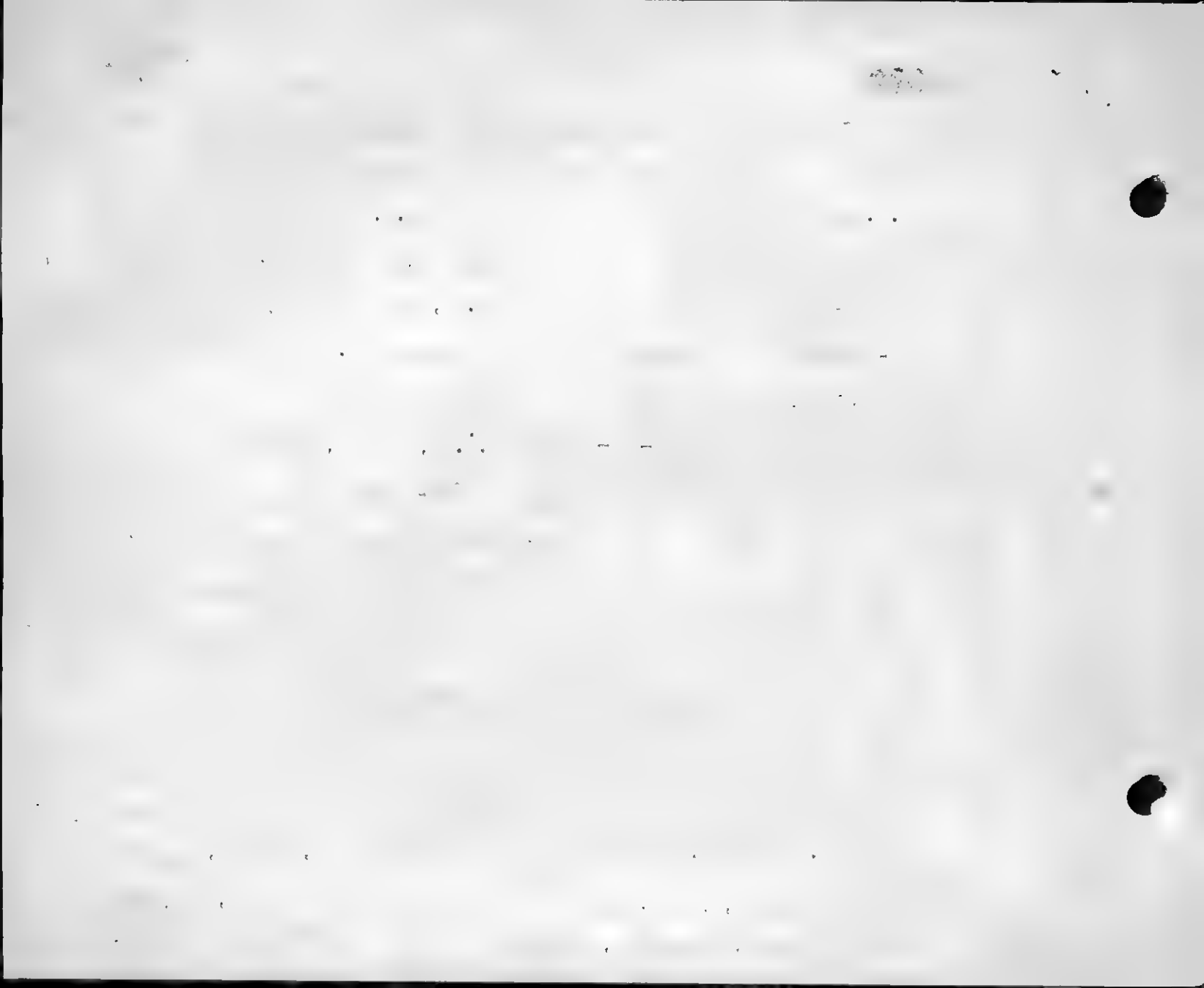
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2 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar c. LENGTH OF STAY IN 1b Delmar d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. #3		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar d. STREET ADDRESS R.D. #3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARCHIE Middle DURAND Last HUMPHREYS		4. DATE OF DEATH Month March Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1889
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 2 Days 22 Hours Min. IF UNDER 24 HRS. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Humphreys		14. MOTHER'S MAIDEN NAME Bertha Twilley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-34-3911	
17. INFORMANT Mr. Lee Edwin Humphreys (Son) R.D. #3, Delmar, Maryland		Address 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 1 week unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED while <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 10/9, 1954 to death , 19 , that (I) (we) last saw the deceased alive on MAR 9 19 67 , and that death occurred at 2 P M, from the causes and on the date stated above.			
22a. SIGNATURE Ernest Larmore		22b. DATE SIGNED March 11 / 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore		22d. ADDRESS Grove Street, Delmar, Delaware	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR MAR 14 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
20 M 1/66

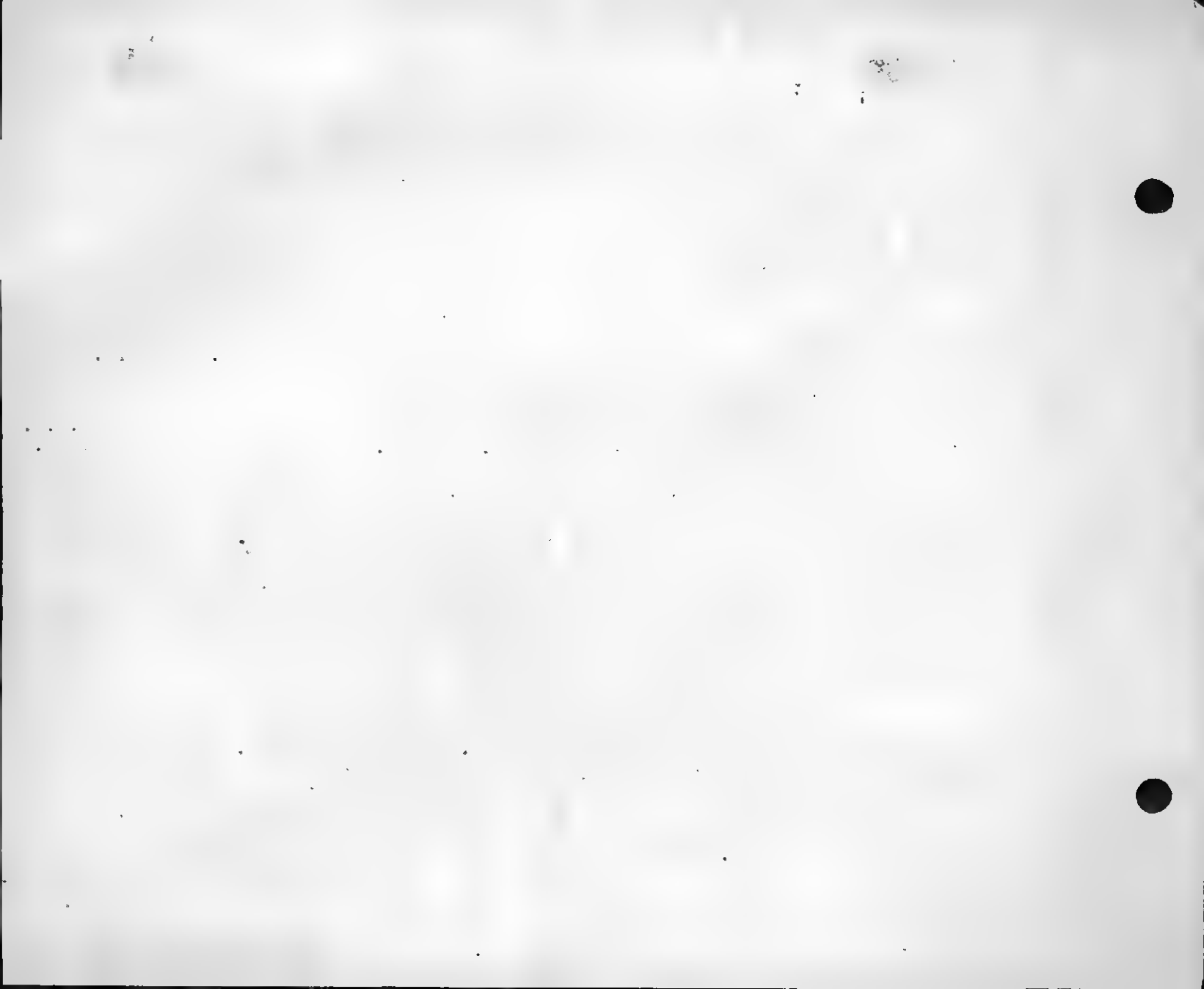
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04393

CERTIFICATE OF DEATH

04395

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 30 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Paul Middle Jenkins Last Jenkins		4 DATE OF DEATH Month March Day 10 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-20-1892
9 AGE (In years lost birthday) 74 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day Laborer	11 BIRTHPLACE (County & State or foreign country) Dorchester County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Robert Jenkins	
14. MOTHER'S MAIDEN NAME Annie Stanley		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO 202-01-5809		17 INFORMANT Address R.F.D. Mrs. Grace H. Jenkins, East New Market, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial failure DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Aneurysm - thoracic aorta DUE TO (c) Hypertensive arteriosclerotic cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 30 mins. years?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Broncho pneumonia and chronic emphysema			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 8, 1967 , to Mar. 10, 1967 , that (I) (we) last saw the deceased alive on March 10, 1967 , and that death occurred at 8:35 P.M. from causes and on the date stated above			
22a SIGNATURE <i>Charles H. Winnacott</i> M.D.		22b. DATE SIGNED 3/11/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.		22d. ADDRESS Deer's Head State Hospital, Salisbury	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 14, 1967	23c. NAME OF CEMETERY OR CREMATORY Thompsons town Cemetery	23d. LOCATION (City or Town) (County) (State) Md. Near East New Market, Md.
24 FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Md.		25a. REC'D BY REGISTRAR MAR 16 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

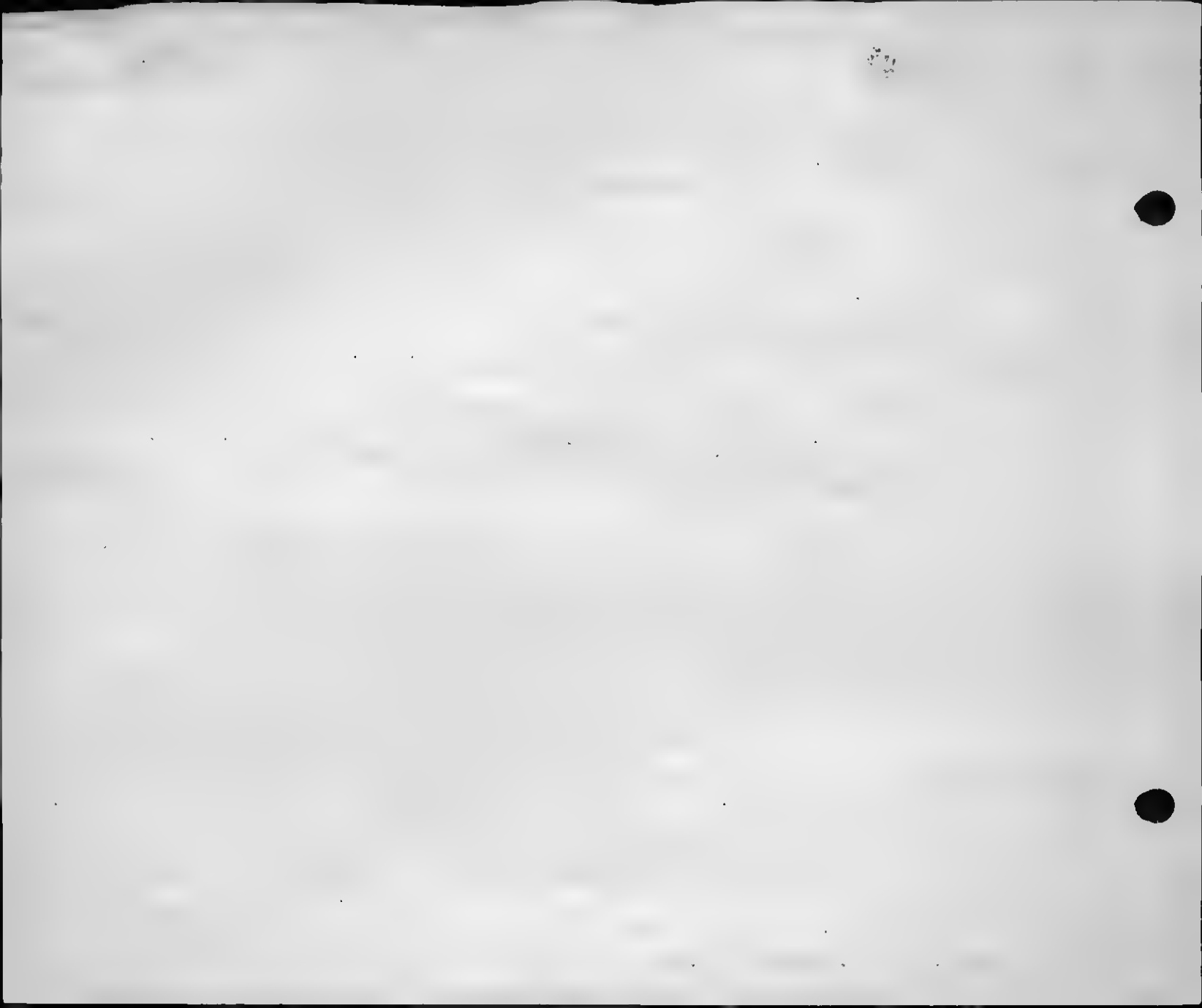
CERTIFICATE OF DEATH

04394

04396

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jesterville</u>	
c. LENGTH OF STAY in 1b <u>Lifetime</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Anna Jones</u>		4. DATE OF DEATH Month Day Year <u>3 - 8 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/3/1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Hase Conway</u>		14. MOTHER'S MAIDEN NAME <u>Jennie H. Lan Kford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-4648</u>	
17. INFORMANT <u>Charles Jones, Jesterville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>3/11/67</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/4</u> 19 <u>67</u> to <u>3/8</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/11</u> 19 <u>67</u> , and that death occurred at <u>12M</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>F. L. Beardsley</u>		22b. DATE SIGNED <u>3/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. L. Beardsley</u>		22d. ADDRESS <u>5215 Gary, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jesterville Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Jesterville, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Massie, Pivallye, Md.</u>		25a. REC'D BY REGISTRAR <u>14 MAR 14 1967</u>	
25b. REGISTRAR'S SIGNATURE			

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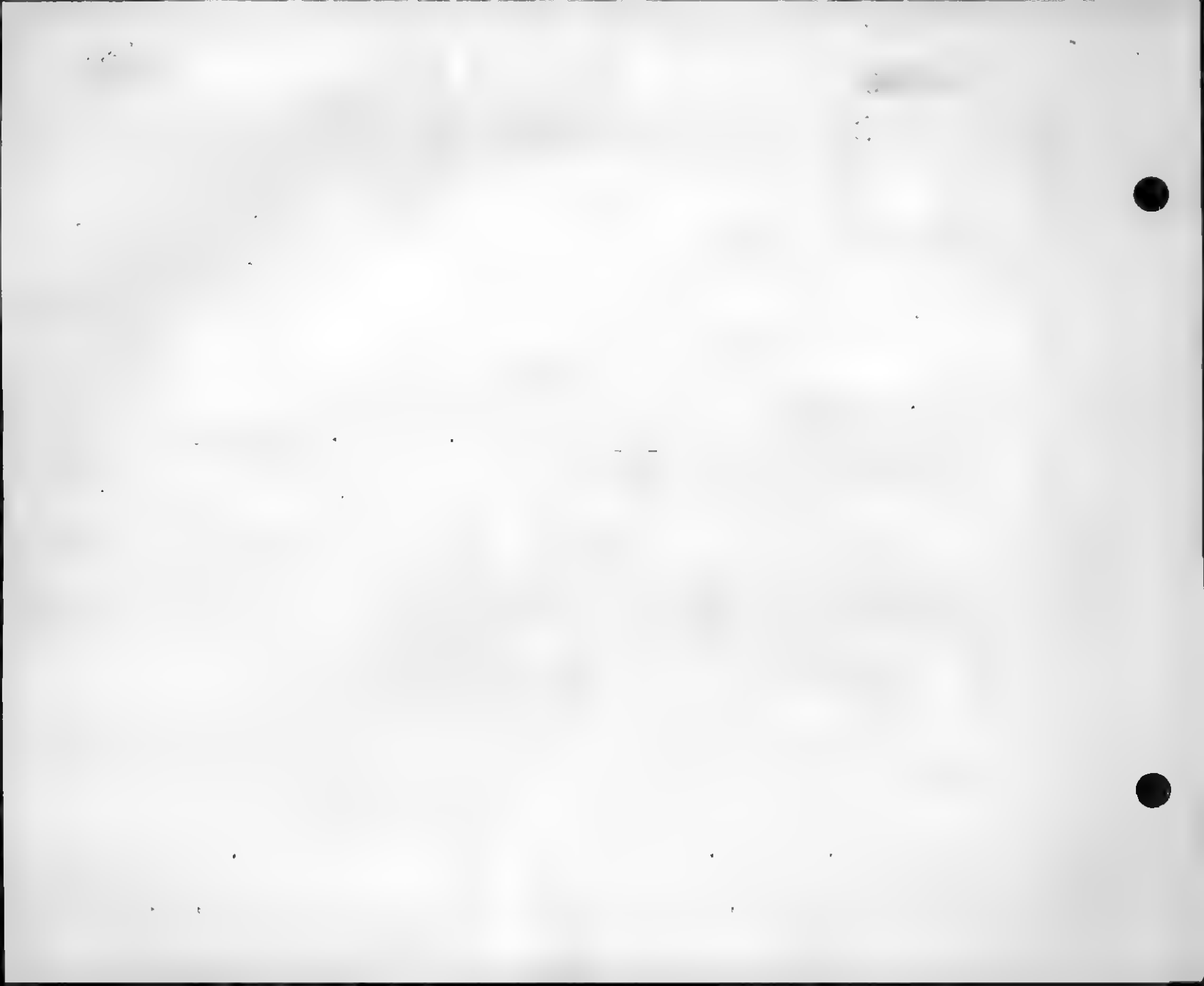
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04395

04397

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Quantico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Cherry Walk Road	
3. NAME OF DECEASED (Type or print) EDNA TAYLOR KOLLE		4. DATE OF DEATH Month MARCH Day 31 Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 15, 1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 1 Days 16 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Taylor		14. MOTHER'S MAIDEN NAME Phoebe Gilbert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 208-12-5263	
17. INFORMANT Mrs. Joseph G. Scott (Daughter)		Address Hebron, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 7 days 10 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/24 , 19 67 , to 3/31/67 , 19 , that (I) (we) last saw the deceased alive on 3/30 , 19 67 , and that death occurred at 5:15 M, from causes and on the date stated above.			
22a. SIGNATURE George H. Henning		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) Dr. George H. Henning		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery	23d. LOCATION (City or Town) (County) (State) Drexel Hill, Pa.
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR APR 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



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VR A15 (4)
20 M 1/66

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

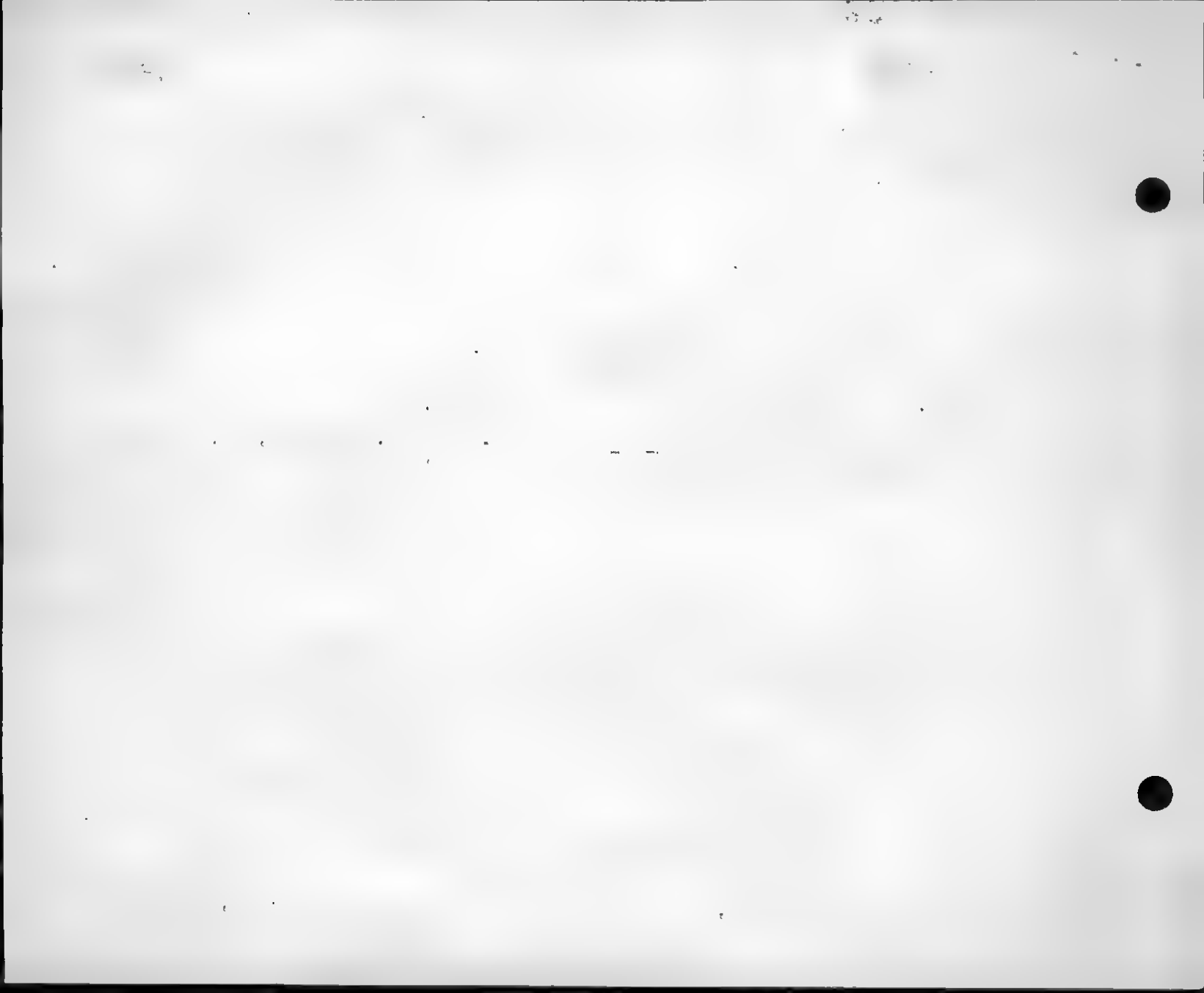
04396

CERTIFICATE OF DEATH

04398

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 709 Beauchamp	
3 NAME OF DECEASED (Type or print) First Miles Middle STANLEY Last Levey		4. DATE OF DEATH Month MARCH Day 12 Year 1967	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-3-87
9 AGE (In years lost birthday) 80 yrs.		10. IF UNDER 1 YEAR Months 2 Days 9 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Magazines	
11 BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (Unk.)		14. MOTHER'S MAIDEN NAME (Unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 216-05-9345	
17. INFORMANT Mr. Ralph B. McIntyre, Sr. (Friend) Sanford, Virginia 23426		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 40 X Congestive Heart Failure DUE TO Hypertensive Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH 2 weeks Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/3/1967 to 3/12/1967 that (I) (we) last saw the deceased alive on 3/12/1967 , and that death occurred at M, from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED March 12/1967	
22c. PHYSICIAN'S NAME (Type) OSWALD BURTON		22d. ADDRESS Med Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 15, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25. REGISTRAR'S SIGNATURE [Signature]	

REC'D BY REGISTRAR
DATE **MAR 14 1967**



04397

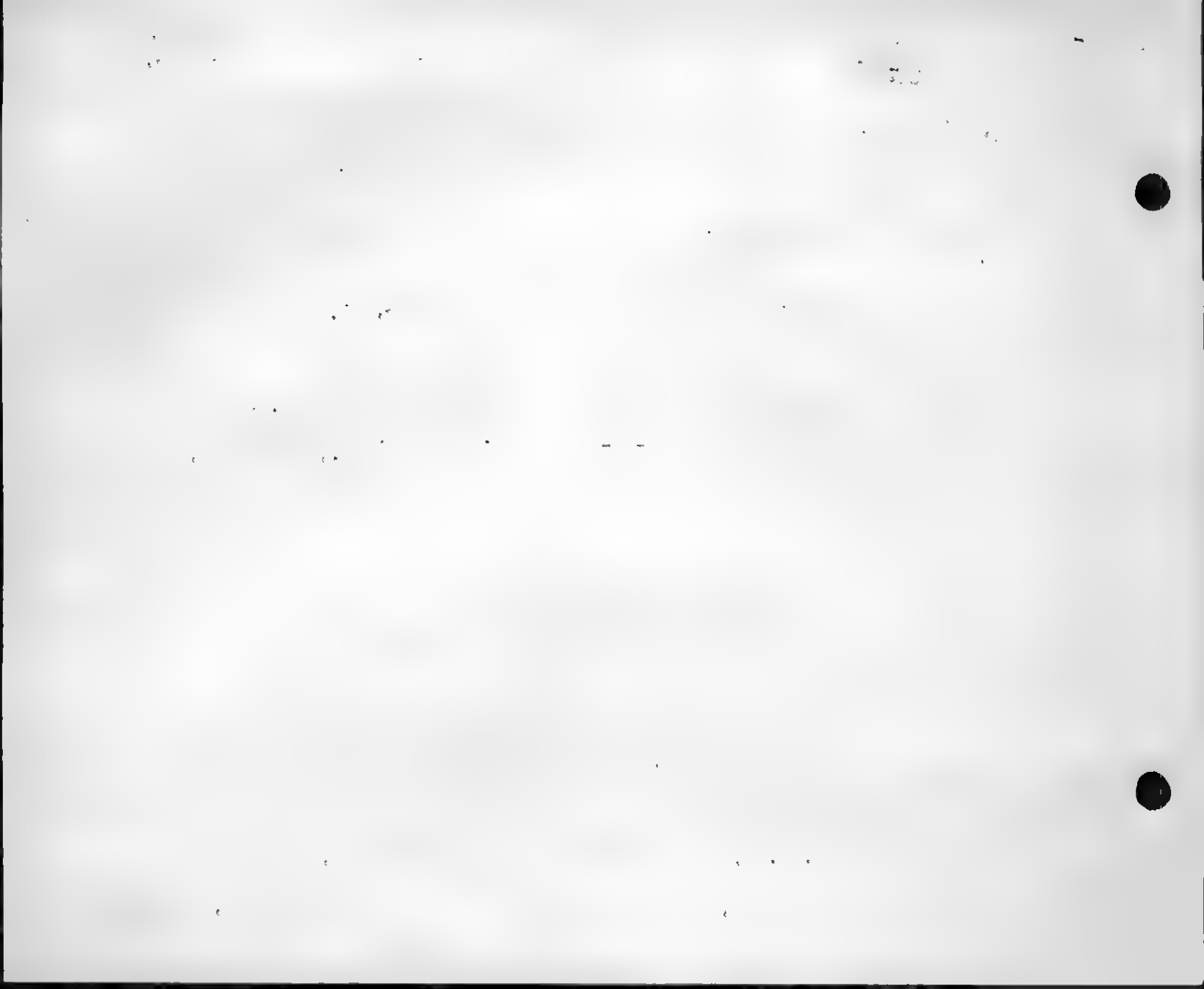
CERTIFICATE OF DEATH

04399

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 1024 Pierce Avenue	
3 NAME OF DECEASED (Type or print) First Middle Last DAVID JOSEPH Logan		4. DATE OF DEATH Month Day Year March 25 1967	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 26, 1937
9. AGE (In years last birthday) 29 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 4 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY New York	
11 BIRTHPLACE (County & State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David John Logan		14. MOTHER'S MAIDEN NAME Ethel Kathleen St. John	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 240-54-0430	
17. INFORMANT Address Mr. David J. Logan (Father) 1024 Pierce Ave., Salisbury, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Monocytic Leukemia. 2042 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 4 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/15/1967 to 3/25/1967 , that (I) (we) last saw the deceased alive on 3/25/1967 , and that death occurred at 7:41 AM , from causes and on the date stated above.			
22a. SIGNATURE Dr. O. J. Burton		22b. DATE SIGNED March 25/1967	
22c. PHYSICIAN'S NAME (Type) Dr. O. J. Burton		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 28, 1967	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR Mar 28 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

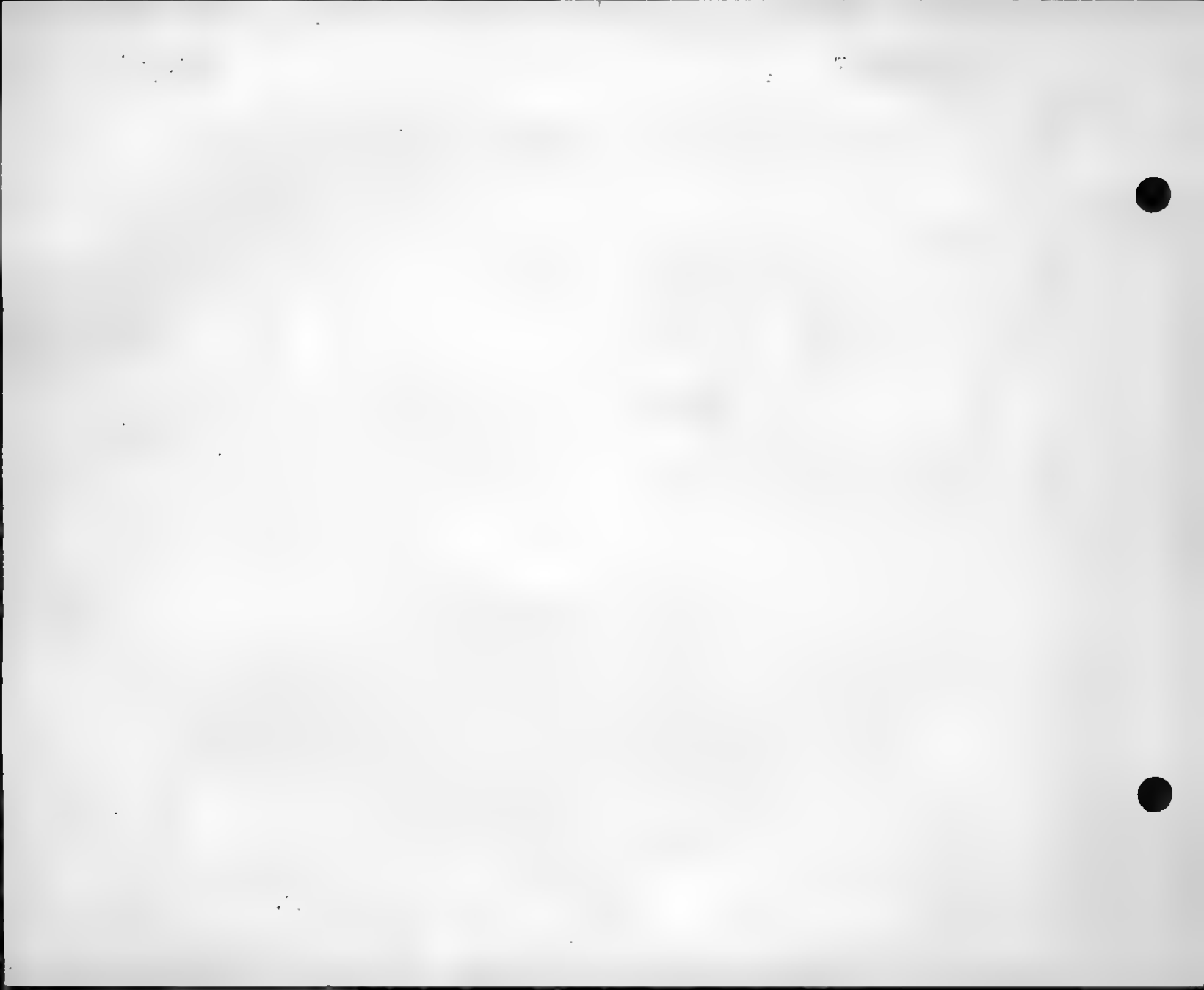
04398

Item #8 Film #3337 4/13/67 DC

CERTIFICATE OF DEATH

04400

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md b. COUNTY Wic			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 204 Naylor St			
3. NAME OF DECEASED (Type or print) Clara First Middle Last Malone				4. DATE OF DEATH March 31 1967 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 2 1887	9. AGE (in years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTH PLACE (County & State, or foreign country) Baltimore md		12. CITIZEN OF WHAT COUNTRY? —	
13. FATHER'S NAME Wm Garnett				14. MOTHER'S M maiden NAME Wood			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Paul Malone Address 2604 Hendon			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH 3 days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 28 1966 , to March 31 1967 , that (I) (we) last saw the deceased alive on March 30 1967 , and that death occurred at 9:15 PM , from causes and on the date stated above.							
22a. SIGNATURE Thomas P. Bigbee				22b. DATE SIGNED March 31, 1967		22c. PHYSICIAN'S NAME (Type) THOMAS P. BIGBEE	
22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/4/67		23c. NAME OF CEMETERY OR CREMATORY Moreland New		23d. LOCATION (City or town) (County) (State) Baltimore md	
24. FUNERAL DIRECTOR W. J. DeLamater 6067 Hay Rd				25a. REC'D BY REGISTRAR APR 5 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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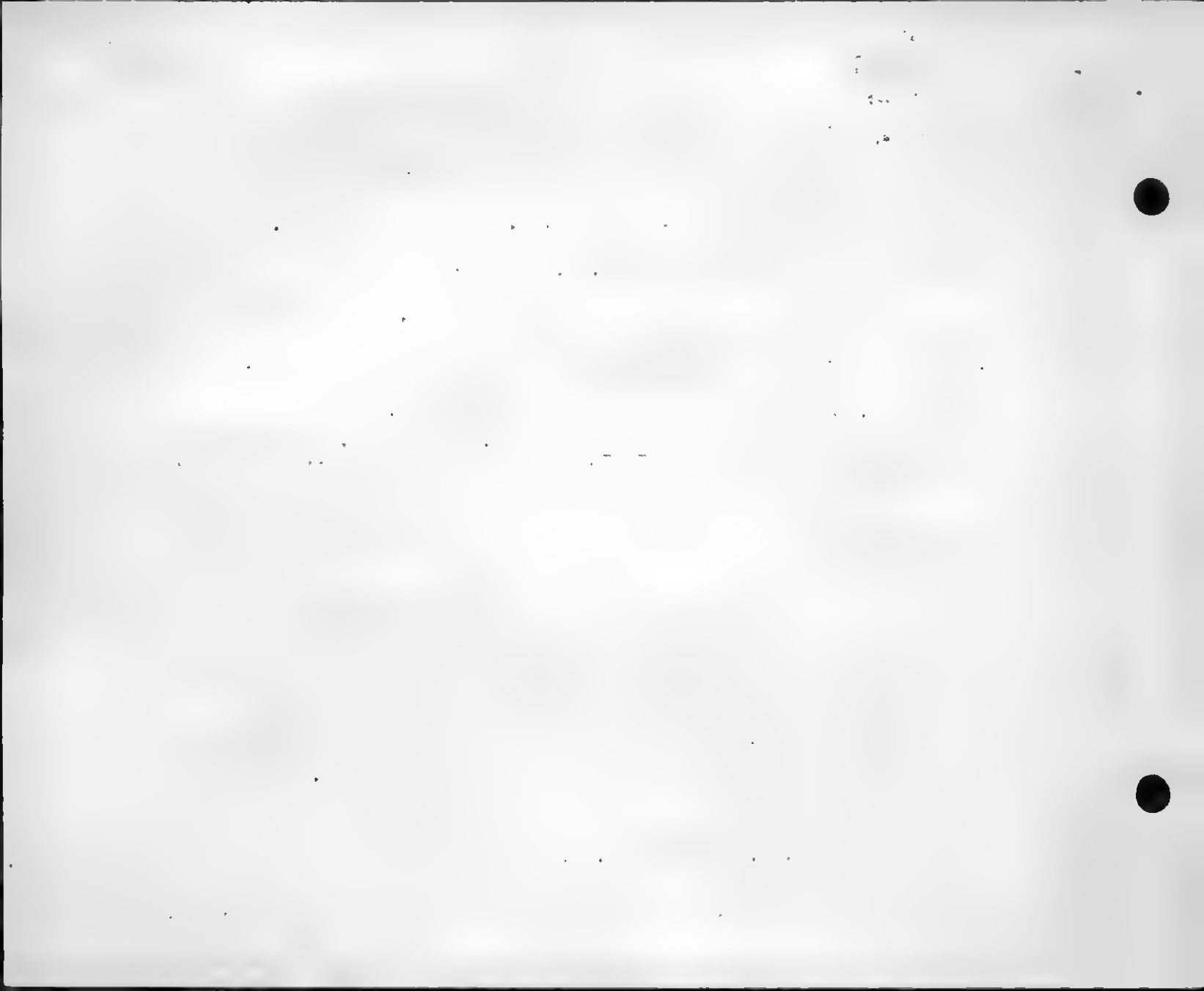
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04399

CERTIFICATE OF DEATH

04401

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 55 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 411 Elizabeth St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type at print) First Joseph Franklin Middle Monroe Last Matthews		4. DATE OF DEATH Month 3 Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1888
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 11 Days 25 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Builder	
11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jackson J. Matthews		14. MOTHER'S MAIDEN NAME Sally M. Parsons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 214-18-4547	
17. INFORMANT Mr. Franklin W. Matthews (Son) 411 Elizabeth St., Salisbury, Maryland		18. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident with hemiplegia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 months Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coma since 1/3/67		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/17 , 1967 , to 3/13 , 1967 , that (I) (we) last saw the deceased alive on 3/13 , 1967 , and that death occurred 7:15 P.M. from causes on and on the date stated above.			
22a. SIGNATURE A. C. Mitchell		22b. DATE SIGNED 3/14/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 16, 1967	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR MAR 16 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

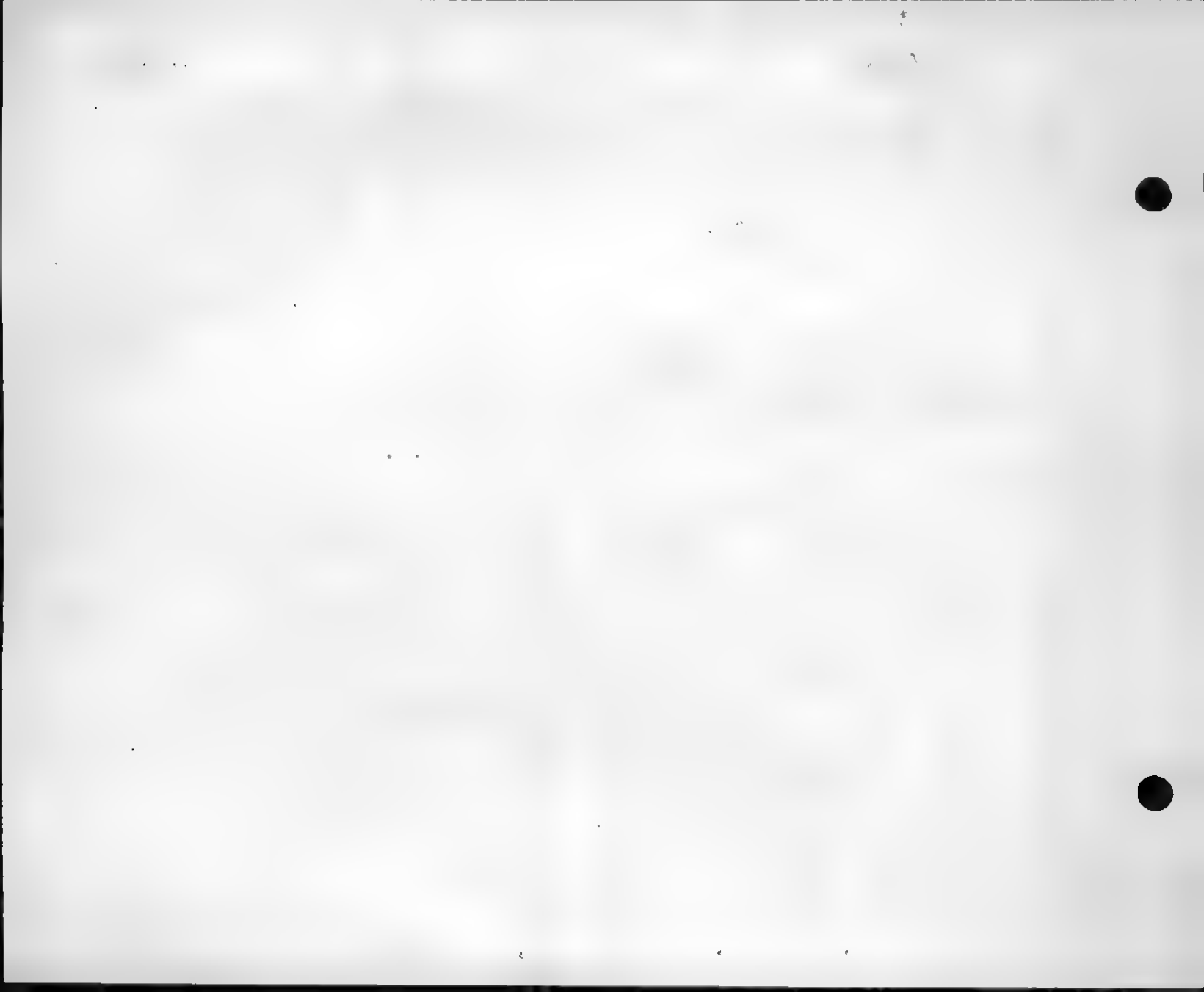
04400

CERTIFICATE OF DEATH

04402

1 PLACE OF DEATH. a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) b. STATE Maryland c. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 30 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 	
3 NAME OF DECEASED (Type or print) Clifford		4. DATE OF DEATH Month March Day 13 Year 1967	
5 SEX Female	6 COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/1892
9. AGE (In years last birthday) 75 yrs.		10. USUAL DECLARATION (Give kind of work done during most of working life, even if retired) House wife	
11. BIRTHPLACE (County & State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Juliah Frances		14. MOTHER'S MAIDEN NAME Anne Dixon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Bishop M.T. McNeal, Princess Anne, Md		 	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thromboses (2) (b) Hypertensive Cardio Vascular Disease (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus. Premia Chronic Glomerulosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/67</u> to <u>3/13/67</u>, that (I) (we) last saw the deceased alive on <u>3/12/67</u>, and that death occurred at <u>4:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 3/13/67	
22c. PHYSICIAN'S NAME (Type) William H. James Jr.		22d. ADDRESS Princess Anne, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/19/67	23c. NAME OF CEMETERY OR CREMATORY Israel Memorial	23d. LOCATION (City or Town) (County) (State) Lottels Maryland
24. FUNERAL DIRECTOR William H. James Jr.		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
5M 1/62

STATE
HEALTH DEPT.

04401
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04403

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN IL 3 hrs.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 115 Kendall st.
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission.)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury
d. STREET ADDRESS 415 Patterson Ave.
3. NAME OF DECEASED (Type or print) Billie Ann Messick
4. DATE OF DEATH March 13, 1967
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☒ 8. DATE OF BIRTH May 14, 1934
9. AGE (In years last birthday) 32 yrs. IF UNDER 1 YEAR: Months 0 Days 0 Hours 0 M. n. IF UNDER 24 HRS.: Months 0 Days 0 Hours 0 M. n.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b. KIND OF BUSINESS OR INDUSTRY Gas Company
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

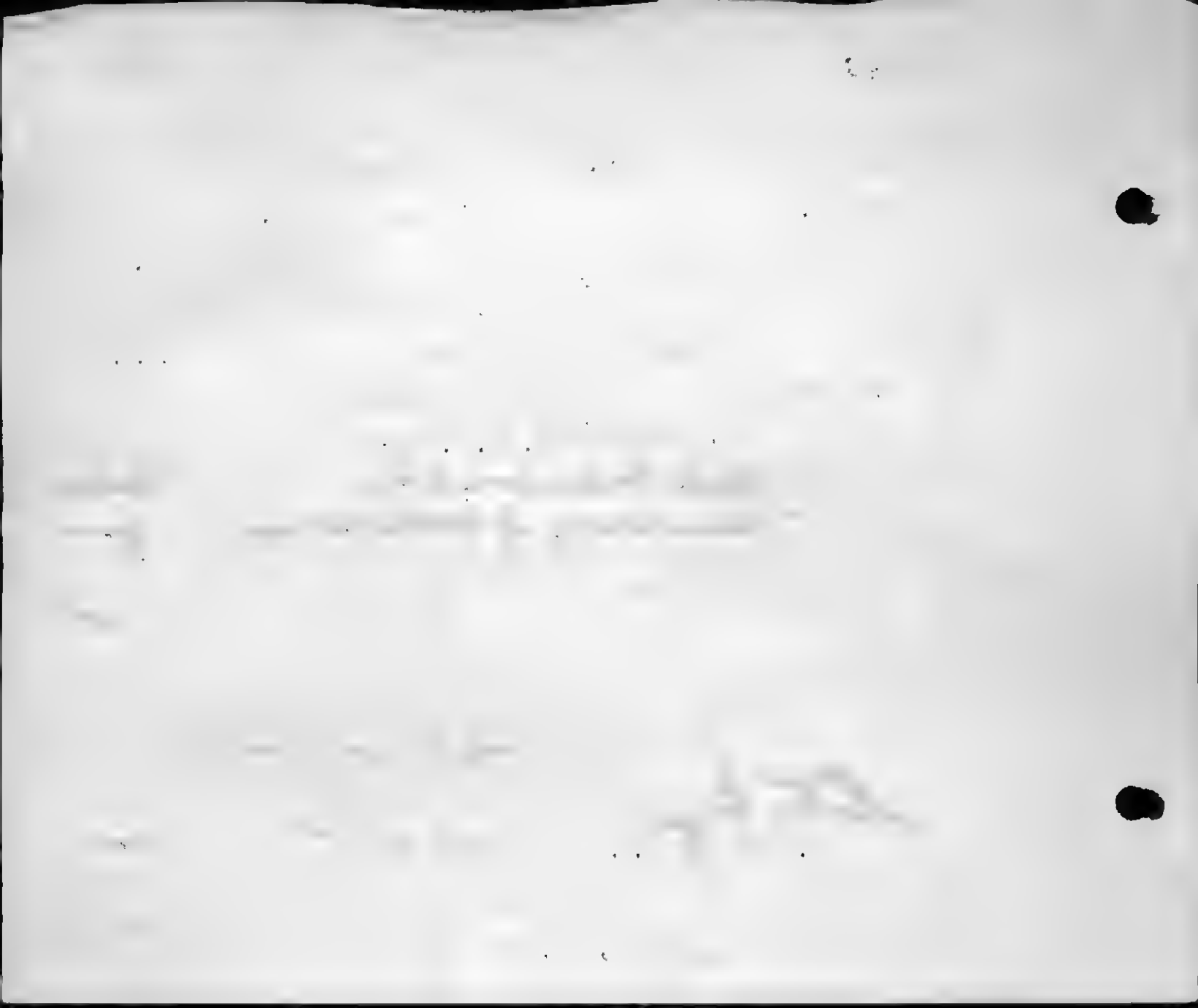
13. FATHER'S NAME William Messick 14. MOTHER'S MAIDEN NAME Annabelle MacLain
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 214-32-0521 17. INFORMANT Mrs. Wm. E. Messick Address See #2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute tracheobronchitis
Conditions, if any, which gave rise to immediate cause (b) Sarcoidosis of mediastinum
(c) due to
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death
1 hour
year

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month 3 Day 16 Year 1967 20d. INJURY OCCURRED While ☐ Not While ☐ at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Maryland 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 3-14-67

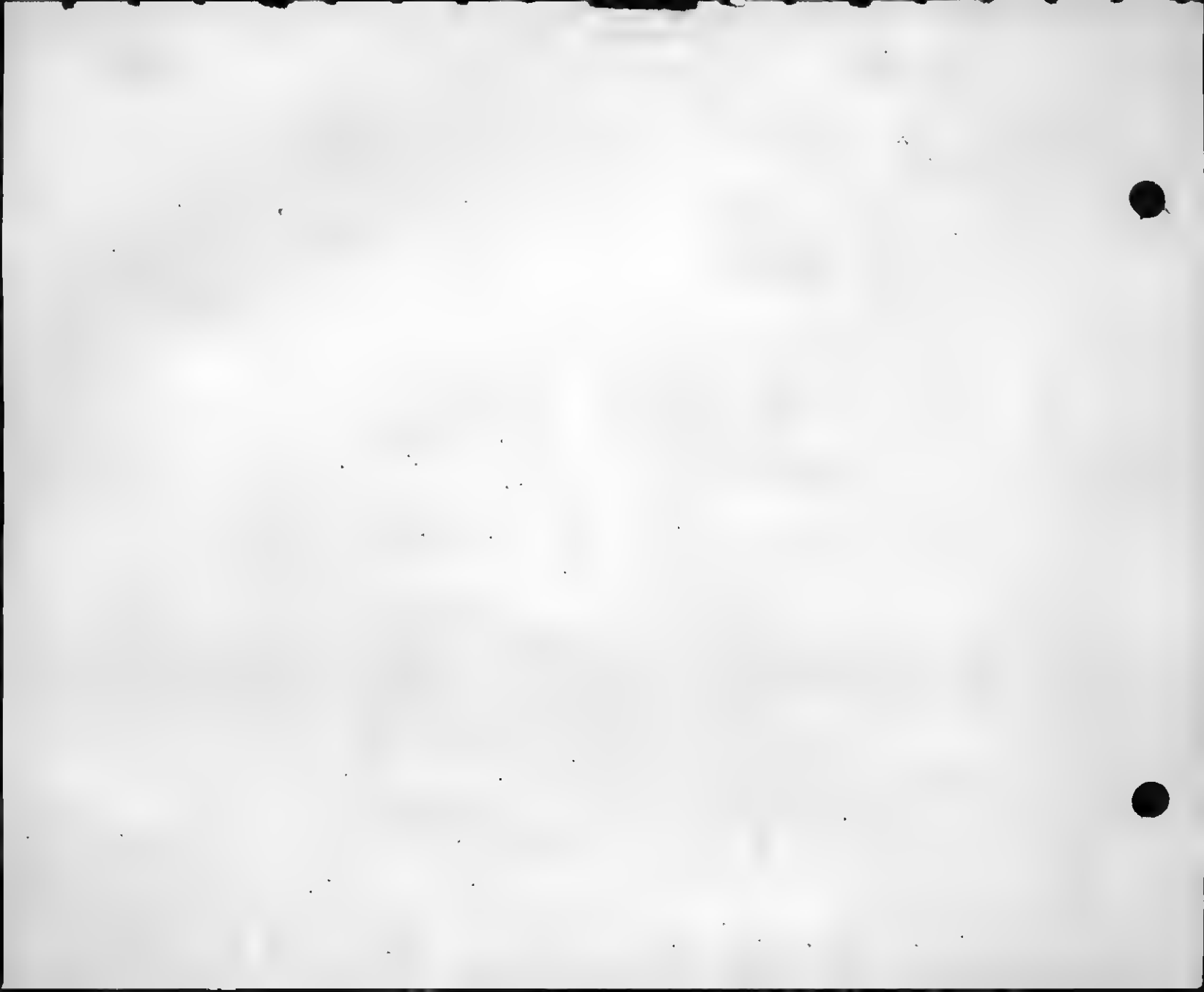
ACTUAL SIGNATURE Earl L. Royer M.D.
EXAMINER'S NAME (Type) Earl L. Royer M.D.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 3/16/1967 22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery 22d. LOCATION (City, town, or country) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR George H. H. H. ADDRESS Salisbury, Maryland
24a. REC'D BY REGISTRAR MAR 16 1967 24b. REGISTRAR'S SIGNATURE Charles Judge



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04402					04404				
Item #1d File									
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
c. LENGTH OF STAY IN 1b <u>2 yrs</u>					d. STREET ADDRESS <u>705 W. Isabella St.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>614 W. Isabella Street</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Oliver</u> Last <u>Milbourne</u>					4. DATE OF DEATH Month <u>3</u> Day <u>16</u> Year <u>1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>AA</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-16-1885</u>		9. AGE (in years last birthday) <u>81</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Accomac Co. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
13. FATHER'S NAME <u>Julius Milbourne</u>					14. MOTHER'S MAIDEN NAME <u>SARAH Copes</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Phyllis Milbourne</u> Address <u>705 W. Isabella St. Salisbury, MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac degenerative heart disease</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Indefinite</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2 Jan</u> 19 <u>67</u> to <u>16 Mar</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 Mar</u> 19 <u>67</u> , and that death occurred at <u>7:20</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>F. A. Parnell</u>					22b. DATE SIGNED <u>21 Mar 67</u>				
22c. PHYSICIAN'S NAME (Type) <u>F. A. Parnell, MD</u>					22d. ADDRESS <u>652 W. Main St. Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>3-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>First Baptist</u>		23d. LOCATION (City, town or county) (State) <u>Mappsville, Va.</u>			
24. FUNERAL DIRECTOR <u>Luella D. Jolly</u> Address <u>Jersey Rd. Rt. 12 Salisbury, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>MAR 31 1967</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

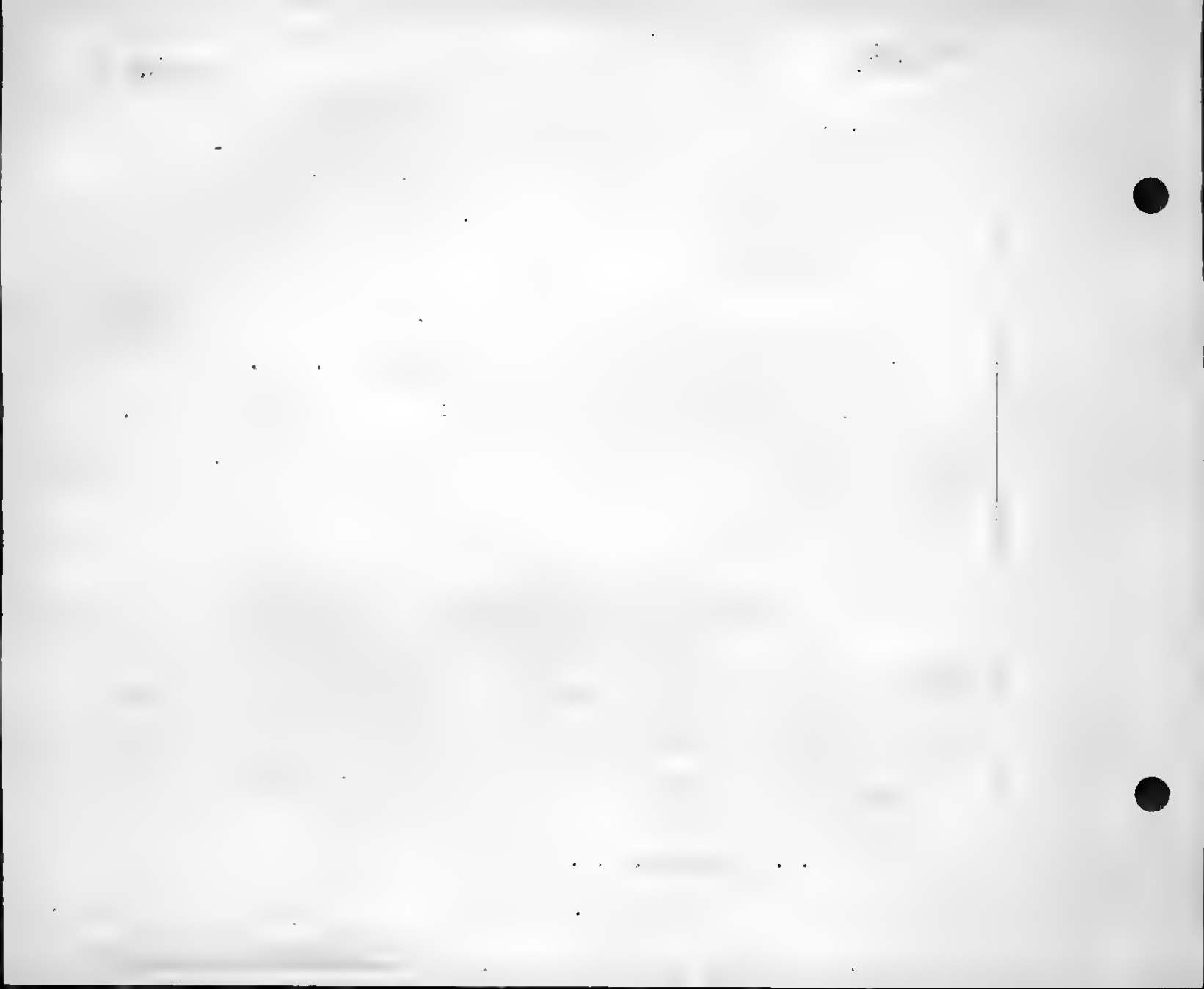
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04403

CERTIFICATE OF DEATH

04405

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b since 3/6/67		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital			d. STREET ADDRESS RFD # 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First Middle Last WARREN DAVID NAIRNE			4 DATE OF DEATH Month Day Year March 24 1967		
5 SEX M	6. COLOR OR RACE C	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1911	9. AGE (in years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Wicomico Co., Md.	
13. FATHER'S NAME Arthur Nairne			14. MOTHER'S MAIDEN NAME Ida Black		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 215-36-0321		17. INFORMANT Records of Pine Bluff Hospital	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH unknown
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/6/1967 to 3/24 1967 , that (I) (we) last saw the deceased alive on 3/24 1967 , and that death occurred at 11:03 pm from causes and on the date stated above.					
22a. SIGNATURE E.P. Ritchings		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/25/67	
22c. PHYSICIAN'S NAME (Type) E.P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/30/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		23d. LOCATION (City or Town) (County) (State) Fruitland Md.	
24. FUNERAL DIRECTOR Walter H. Stewart - Md.		25a. REC'D BY REGISTRAR DATE MAR 30 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

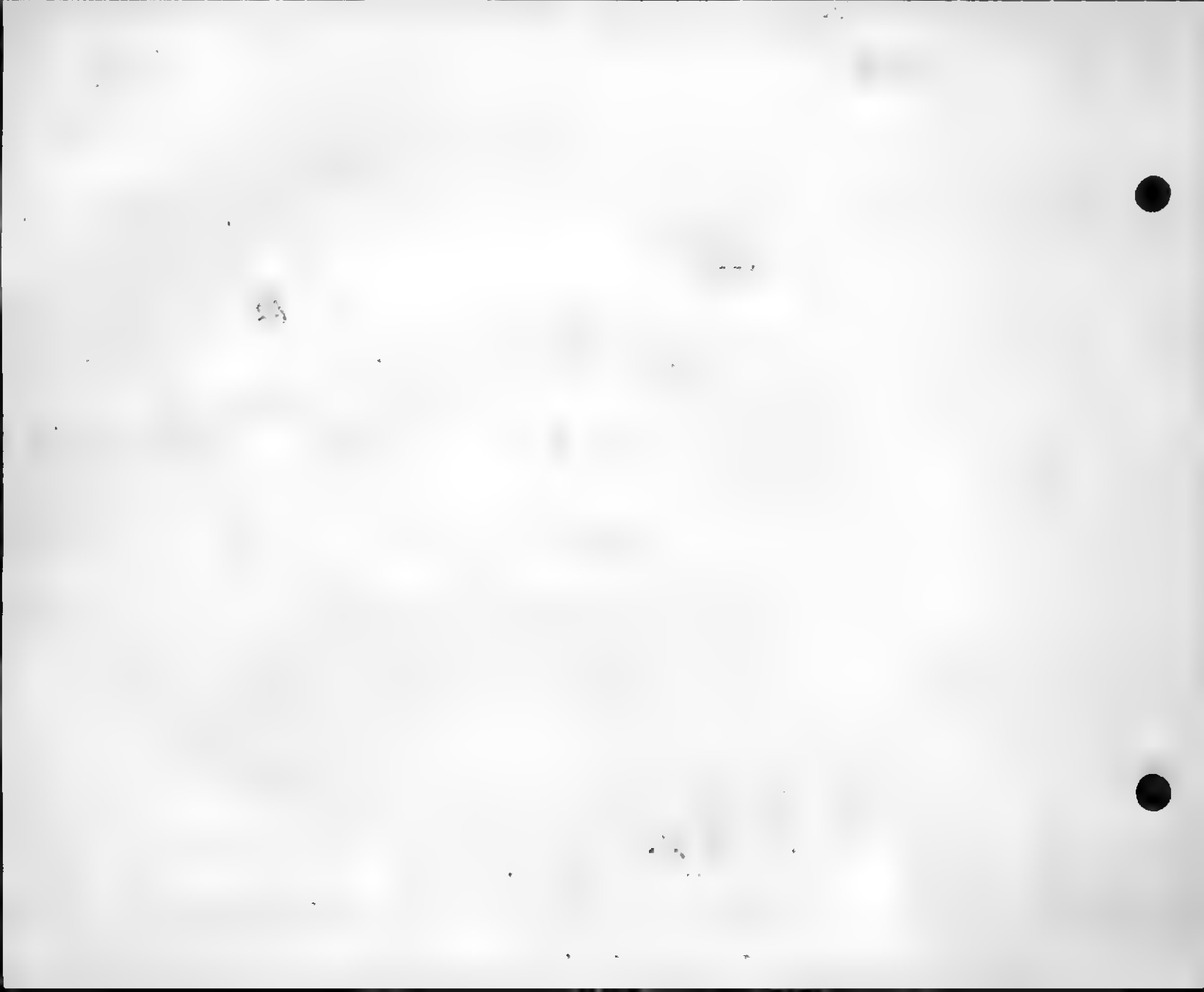
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04404

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04406

1. PLACE OF DEATH a COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d STREET ADDRESS 408 Patrick Ave.	
3 NAME OF DECEASED (Type or print) First Morris Middle NUTTER Last NUTTER		4 DATE OF DEATH Month March Day 29 Year 1967	
5 SEX Male	6 COLOR OR RACE AA	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH MAY 15, 1904
9 AGE (In years last birthday) 62 yrs		10 IF UNDER 24 HRS Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		11 BIRTHPLACE (State or foreign country) Mt. Vernon	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME Jim Nutter	
14 MOTHER'S MAIDEN NAME Rebecca Bloodworth		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO. 220-10981		17 INFORMANT DORA NUTTER Address 408 Patrick Ave. Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			INTERVAL BETWEEN ONSET AND DEATH sudden years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED March 30, 1967	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-3-67	23c. NAME OF CEMETERY OR CREMATORY St. Paul's Methodist	23d. LOCATION (City or Town) (County) (State) Mt. Vernon Somerset Md.
24 FUNERAL DIRECTOR Jolley Funeral Home, Salisbury, Md.		25. REGISTRY BY REGISTRAR DATE APR 5 1967	
25. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be filed as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

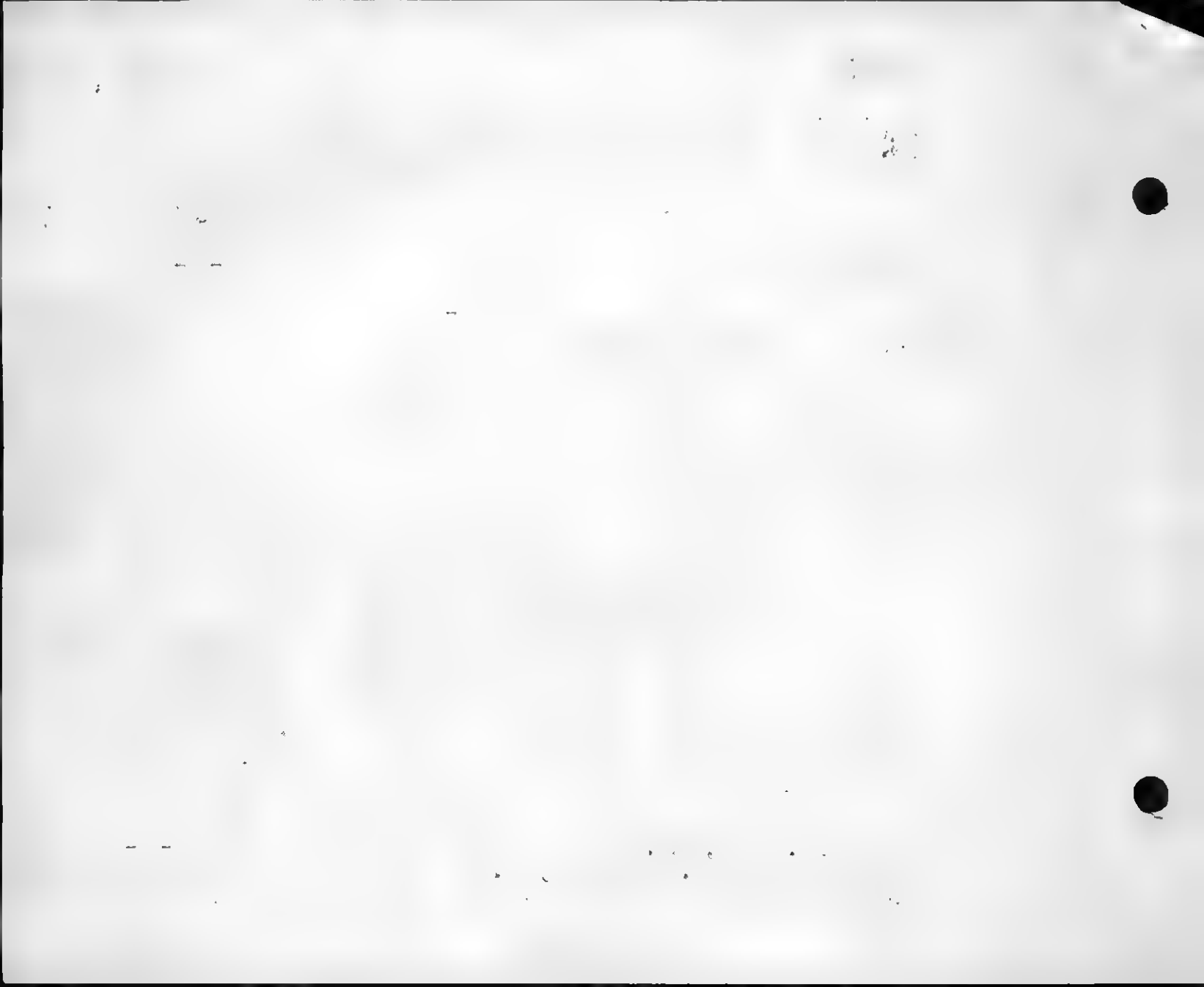
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04405

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04407

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 15 Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Route # 1 Box 185	
3 NAME OF DECEASED (Type or print) Melvin Leroy Parsons		4 DATE OF DEATH 3-18-67 19	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10-17-20
9. AGE (in years last birthday) 46 yrs		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) Repair		10b. KIND OF BUSINESS OR INDUSTRY Body Shop	
11 BIRTHPLACE (State or foreign country) Md		12 CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO WW 11	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m p m 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D.		22. DATE SIGNED 3-18-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3/22/67	23c. NAME OF CEMETERY OR CREMATORY Balto Nat'l Cem
24. FUNERAL DIRECTOR McCully F H		25a. REC'D BY REGISTRAR MAR 23 1967	
ADDRESS 237 Patapsco Ave 21225		25b. REGISTRAR'S SIGNATURE J Charles Judge	
LOCATION (City or Town) (County) (State) Baltimore Md			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

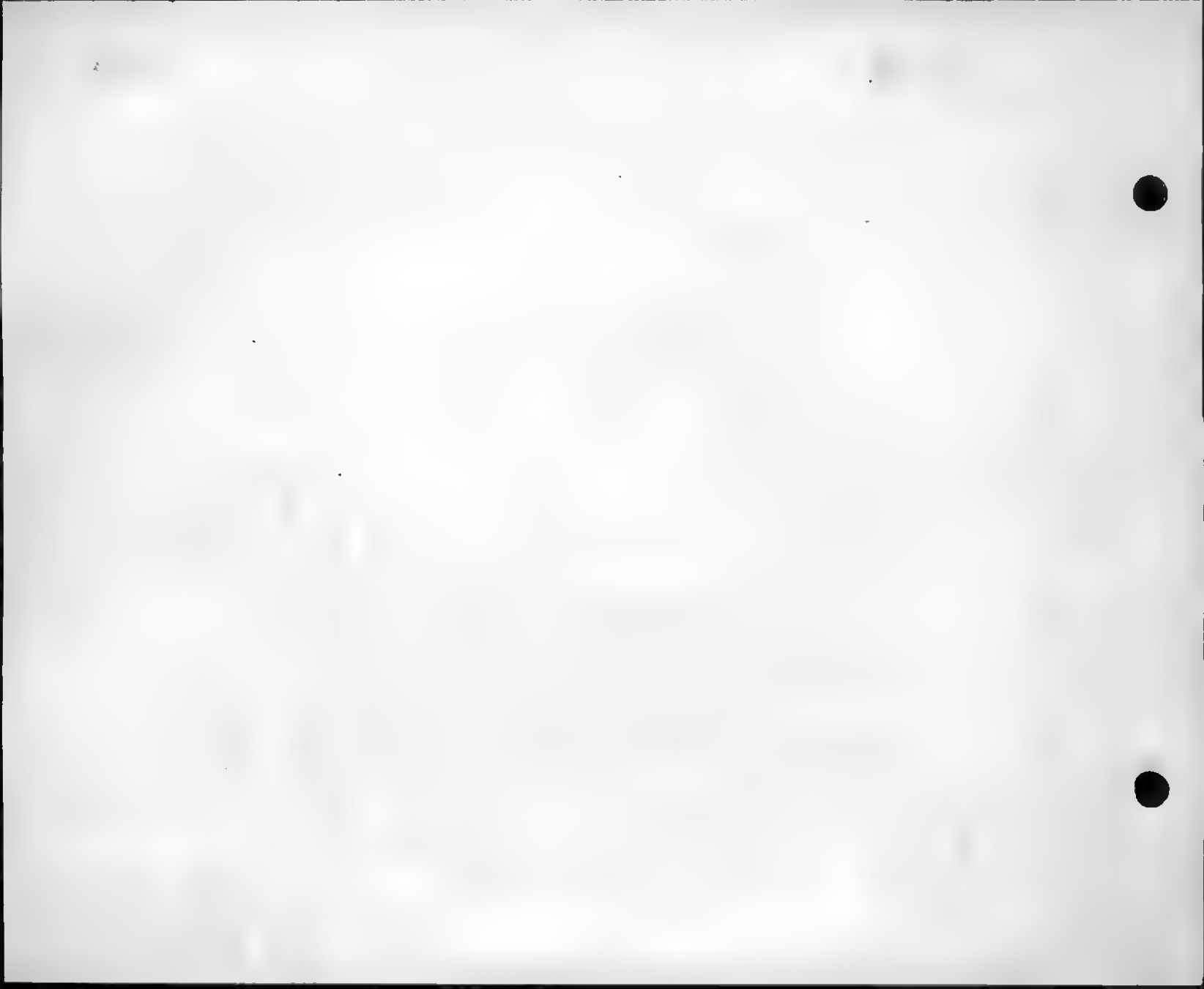
04406

CERTIFICATE OF DEATH

04408

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>13 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS 	
3. NAME OF DECEASED (Type or print) <u>Mimie Lee Perry</u>		4. DATE OF DEATH Month <u>March</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boxer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME 		14. MOTHER'S MAIDEN NAME <u>Amanda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>219-07-6308</u>	
17. INFORMANT <u>Ralph Jones</u>		Address <u>Nanticoke, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>aluminum Gastro Enteritis</u> DUE TO <u>1761</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Medicinal Therapy</u> DUE TO (c) <u>Adeno Carcinoma Vagina</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 week</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>3/16</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robbie Chris Kusew</u>		22b. DATE SIGNED <u>3/16/67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Nanticoke, Md.</u>
24. FUNERAL DIRECTOR <u>C. J. Messing, RIV 316, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



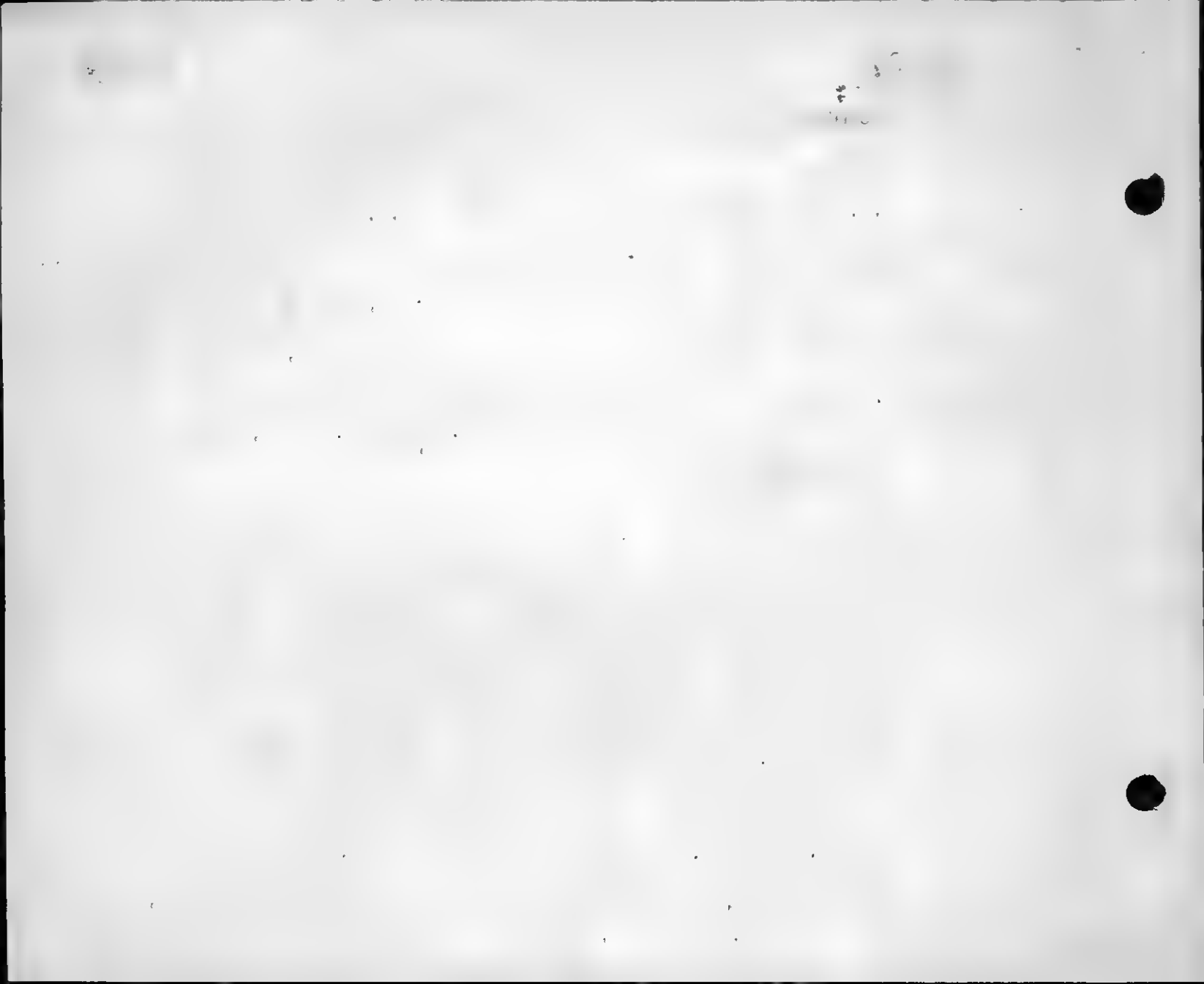
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04407

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04409

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN ID MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. #1		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS R.D. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MAMIE VIRGINIA PHILLIPS		4. DATE OF DEATH Month March Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 2, 1889
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 6 Days 22 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alfred F. Pusey		14. MOTHER'S MAIDEN NAME Nancy Ellen Smullen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Mattie E. Rayne, (Daughter) Box 71, Fruitland, Maryland		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary occlusion, probable 4401 DUE TO (b) coronary atherosclerosis, severe DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH sudden years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 60 , to MAR , 19 67 , that (I) (we) last saw the deceased alive on March 4 , 19 67 , and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Robert T. Akins		22b. DATE SIGNED March 25, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Akins		22d. ADDRESS Fruitland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 27, 1967	
23c. NAME OF CEMETERY OR CREMATORY Zion Cemetery		23d. LOCATION (City, town or county) (State) Worcester County, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR MAR 27 1967 DATE	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

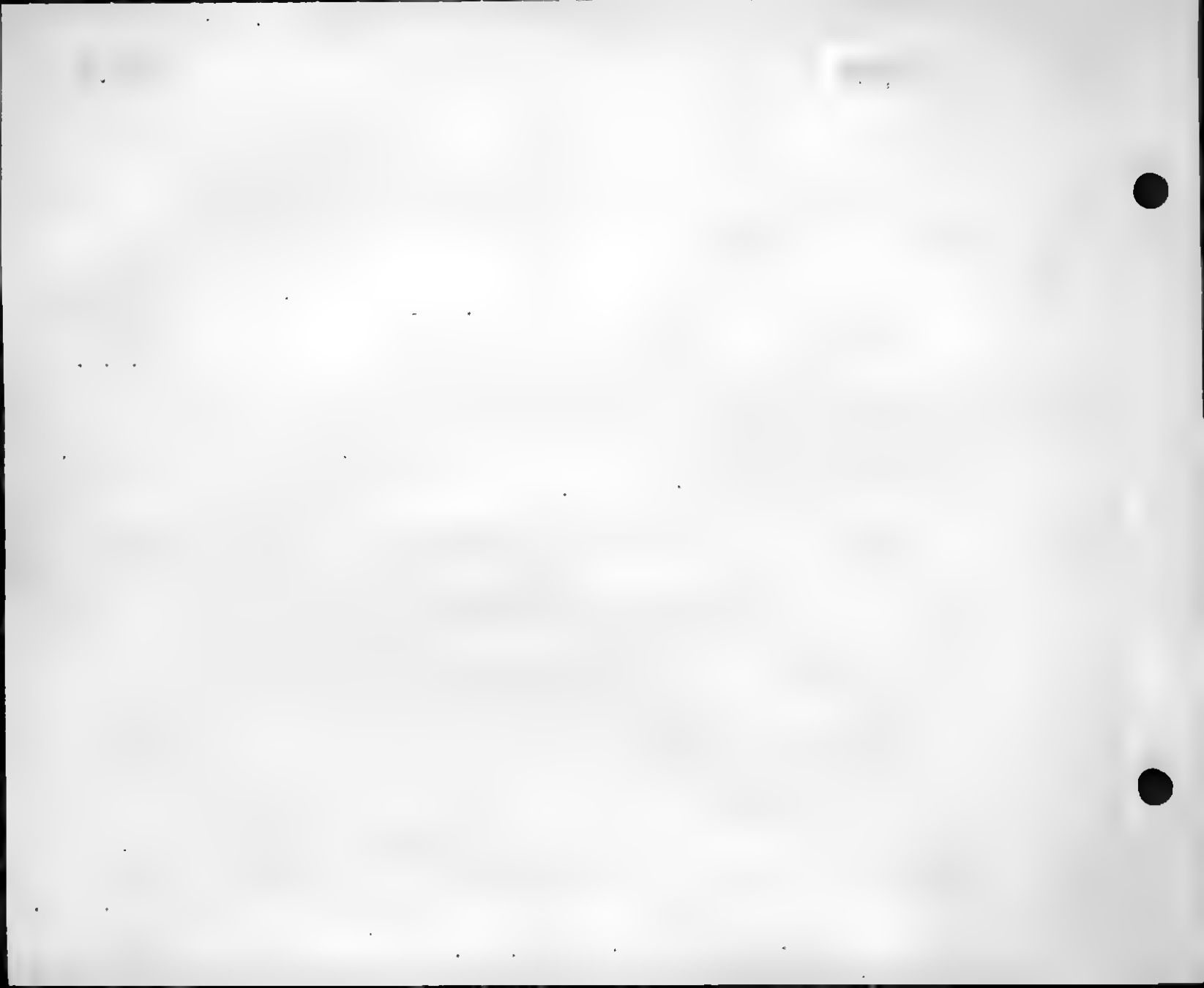
MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04408

CERTIFICATE OF DEATH

04410

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN IT 18 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				e. STREET ADDRESS Market Street			
3. NAME OF DECEASED (Type or print) First IRA Middle HERMAN Last PILCHARD				4. DATE OF DEATH Month MARCH Day 18 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1883	
9. AGE (In years last birthday) 83 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesclerk		10b. KIND OF BUSINESS OR INDUSTRY Retail Clothing		11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Thomas Pilchard			
14. MOTHER'S MAIDEN NAME Elizabeth Hancock				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. none				17. INFORMANT Mrs Roy Mason, Pocomoke City, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction - 4201 OUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) None (c) None							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Salisbury				20g. (County) Worcester		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from 3/17/67 to 3/18/67 that (I) (we) last saw the deceased alive on 3/17/67 , and that death occurred at 8:00 M, from causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 3/18/67			
22c. PHYSICIAN'S NAME (Type) Oswald Burton				22d. ADDRESS Medical Center, Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-20-1967		23c. NAME OF CEMETERY First Baptist		23d. LOCATION (City or Town) (County) (State) Pocomoke City Wor. Md.	
24. FUNERAL DIRECTOR Robert H. Watson				25a. REC'D BY REGISTRAR Robert H. Watson			
25b. REGISTRAR'S SIGNATURE [Signature]				25c. DATE MAR 21 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20 M 1/66

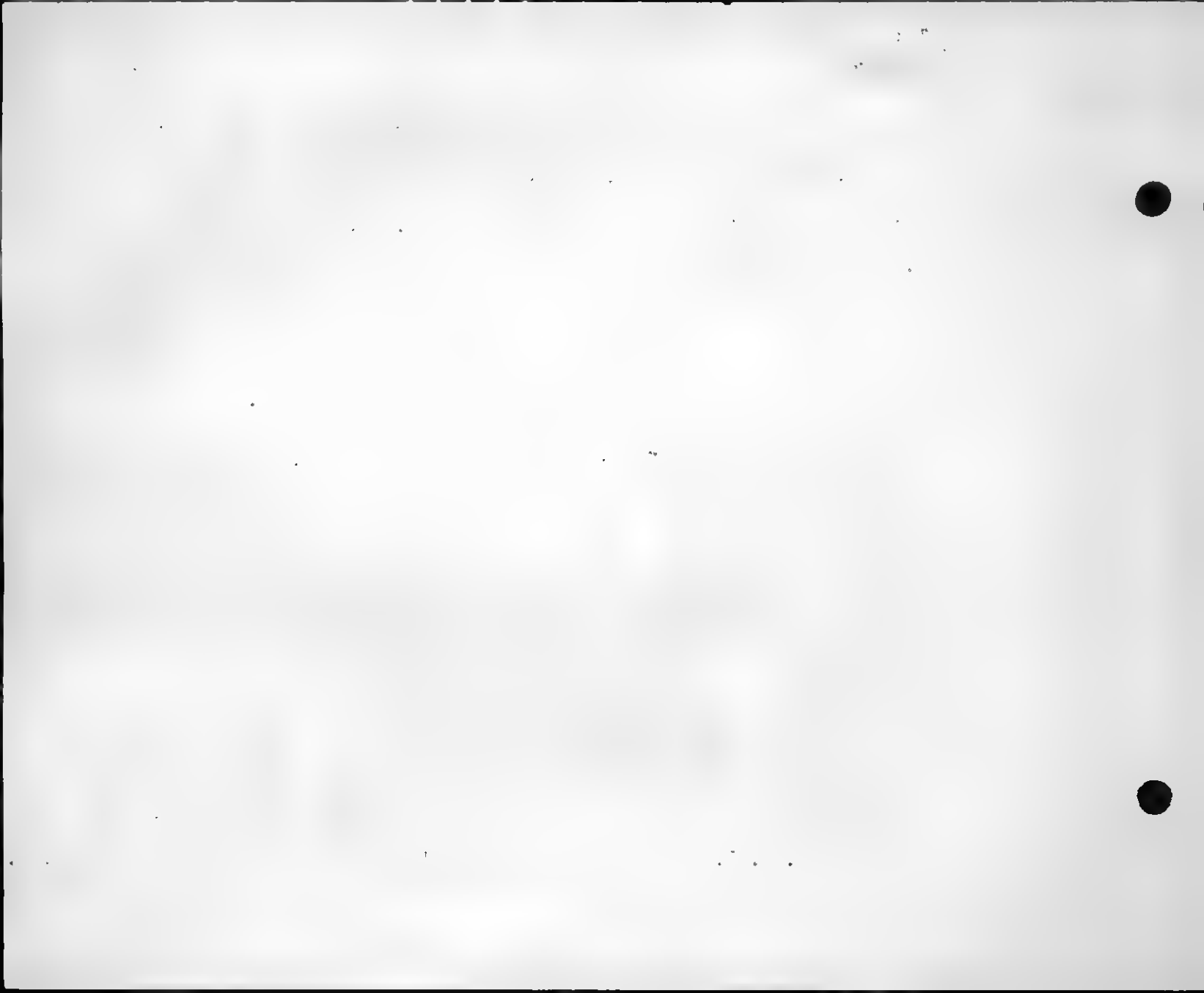
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04409

CERTIFICATE OF DEATH

04411

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 45 minutes	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Rt. #3, Box 276	
3. NAME OF DECEASED (Type or print) Jesse M PURNELL		4. DATE OF DEATH Month March Day 7 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-18-1896
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LABORER	
11. BIRTHPLACE (County & State, or foreign country) Worcester		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Thomas Purnell		14. MOTHER'S MAIDEN NAME Nancy Waters	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 216-14-2905A	
17. INFORMANT Katherine Purnell		Address Berlin, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5810 IMMEDIATE CAUSE (a) Arteriosclerosis of heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 7, 1967 , to March 7, 1967 , that (I) (we) last saw the deceased alive on March 7, 1967 , and that death occurred at 11:45 AM , from causes on and on the date stated above.			
22a. SIGNATURE A.C. Mitchell		22b. DATE SIGNED 3-7-67	
22c. PHYSICIAN'S NAME (Type) Dr. A. C. Mitchell		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE THEREOF 3-11-67	23c. NAME OF CEMETERY OR CREMATORY Evergreen	23d. LOCATION (City or Town) (County) (State) Berlin, Md. Ave.
24. FUNERAL DIRECTOR Louise B. Jolley - Jersey Rd. Rt. 2 Salis.		25a. REC'D BY REGISTRAR MAR 16 1967	25b. REGISTRAR'S SIGNATURE Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04410

04412

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>112 E. London Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>112 E. London Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>LAURA</u> (NMI) <u>PUSEY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1967</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 3, 1885</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>11</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
13. FATHER'S NAME <u>George Crissey</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mary Z. Heiser, Snow Hill, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Eurhythm in Heart</u> DUE TO (b) <u>Myocarditis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> <u> </u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>							
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> a.m. <u> </u> p.m. <u>4:30</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury, Wicomico</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>March 19, 1967</u> to <u>March 19, 1967</u> that (I) (we) last saw the deceased alive on <u>March 19, 1967</u>, and that death occurred at <u> </u> from the causes and on the date stated above							
22a. SIGNATURE <u>Carrie Hearn</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>226 N. Division St., Salisbury, Maryland</u>		22b. DATE SIGNED <u>March 16, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Carrie Hearn</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>March 20, 1967</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>		23d. LOCATION (City, town or county) <u>Worcester County, Maryland</u>			
25. BODY PREPARED BY <u>MAR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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VR A15 (4)
20 M 1/66

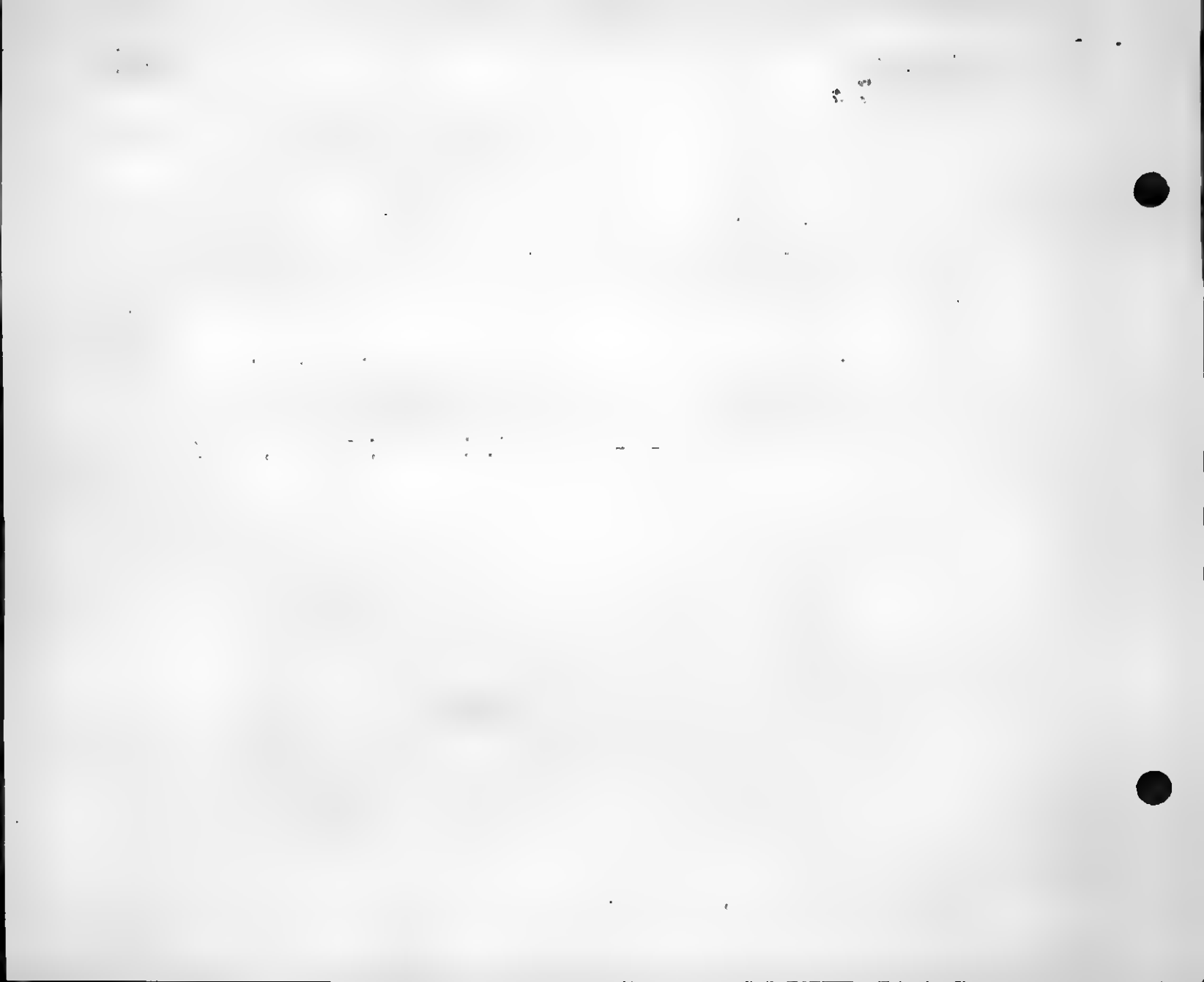
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04411

CERTIFICATE OF DEATH

04413

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN IS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Main Street	
3. NAME OF DECEASED (Type or print) CLYDE ELDERDICE REDDISH		4. DATE OF DEATH Month MARCH Day 18 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-8-06
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wicomico Co. Custodian		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Edward Reddish		14. MOTHER'S MAIDEN NAME Fannie Lee Phillips	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 212-14-4718	
17. INFORMANT Mrs. Erna M. Reddish (Wife) P.O. Box 99, Mardela, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Central thrombosis DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-10-67 , 19 67 to 3-10-67 , 19 67 , that (I) (we) lost saw the deceased alive on 3-10-67 , 19 67 , and that death occurred at 10:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Wilbur R. Ellis, Jr.		22b. DATE SIGNED 3-18-67	
22c. PHYSICIAN'S NAME (Type) WILBUR R. ELLIS, JR.		22d. ADDRESS MEDICAL CENTER, SALISBURY, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 21, 1967	23c. NAME OF CEMETERY OR CREMATORY Mardela Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Mardela, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR MAR 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04412

CERTIFICATE OF DEATH

04414

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b ORIOLE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ORIOLE d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Irene First Middle Last Reid				4. DATE OF DEATH Month Day Year March 29 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 4, 1933	
9. AGE (in years lost birthday) yrs. 33		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DAMES QUARTER, MD.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HARRY BOZMAN			
14. MOTHER'S MAIDEN NAME GLADYS WEBSTER				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 220-28-2020			
16. SOCIAL SECURITY NO. 220-28-2020				17. INFORMANT Address RICHARD REID ORIOLE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebrovascular accident, left DUE TO Severe Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days Not known							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/26/1967 , to 3/29/1967 , that (I) (we) last saw the deceased alive on 3/26/1967 and that death occurred at 5:28 AM , from causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED APR 6 1967		22c. PHYSICIAN'S NAME (Type) LEVIN R. WILSON	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 3/31/1967		23c. NAME OF CEMETERY OR CREMATORY OLIVER BEECHWOOD CEM. PRINCESS ANNE, MD.	
24. FUNERAL DIRECTOR LEVIN R. WILSON				25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE [Signature]	



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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04413

CERTIFICATE OF DEATH

04415

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 556 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Camden Avenue	
3. NAME OF DECEASED (Type or print) Russell Truitt ROBERTS		4. DATE OF DEATH Month March Day 5 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/20/1891
9. AGE (In years lost birthday) yrs 75		10. IF UNDER 1 YEAR Months 5 Days 19 Hours 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labrador		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? America	
13. FATHER'S NAME Thomas S. Roberts		14. MOTHER'S MAIDEN NAME Margaret P. Collier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) —		16. SOCIAL SECURITY NO 572-16-8790	
17. INFORMANT Thomas S. Roberts		Address Baltimore, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 Congestive heart failure DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Pulmonary tuberculosis			INTERVAL BETWEEN ONSET AND DEATH 6-8 weeks Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural effusion (left), probably tuberculosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from August 26 , 19 65 , to March 5 , 19 67 , that (I) (we) last saw the deceased alive on March 5 , 19 67 , and that death occurred at 1:00 P.M. from causes and on the date stated above.			
22a. SIGNATURE C. H. Winnacott		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) Dr. C. H. Winnacott		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/8/67	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem.	23d. LOCATION (City or Town) (County) (State) Jonestown, Md.
24. FUNERAL DIRECTOR C. H. Winnacott		25. RECEIVED BY REGISTRAR 10 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

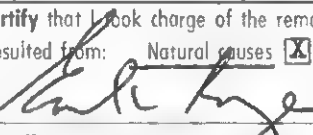

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

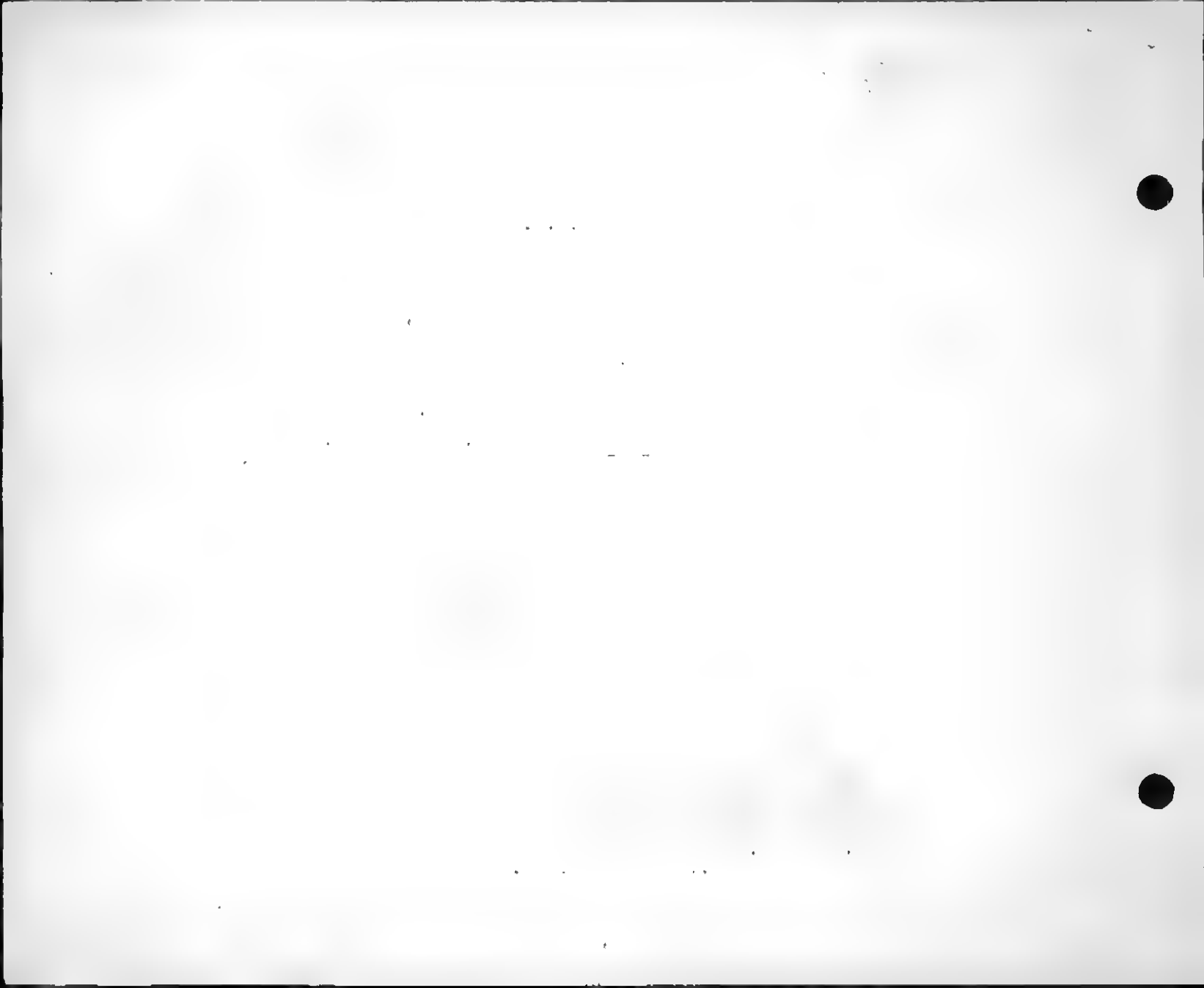
VR A15ME (3)
6M 1/66

04414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04416

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital D.O.A.		d. STREET ADDRESS 306 Pineway	
3 NAME OF DECEASED (Type or print) First Middle Last EDGAR LEE RUSH		4 DATE OF DEATH Month Day Year March 1 19 67	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH July 20, 1910
9 AGE (In years last birthday) 56 yrs		10 IF UNDER 1 YEAR Months Days Hours 7 11	11 FINDER 24 HRS Min. 11
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Manager		10b KIND OF BUSINESS OR INDUSTRY Clothing	
11. BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Charlie Rush		14 MOTHER'S MAIDEN NAME (Unk.)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 225-03-2720	
17 INFORMANT Mrs. Virginia L. Rush (Wife)		Address 306 Pineway, Salisbury, Maryland	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured aortic aneurysm - abdominal DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Minutes
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Dr. Earl L. Royer 409 Camden Ave., Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) March 2 /1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens	23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE MAR 3 1967	25b. REGISTRAR'S SIGNATURE 



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A11 (4)
20 M 1/66

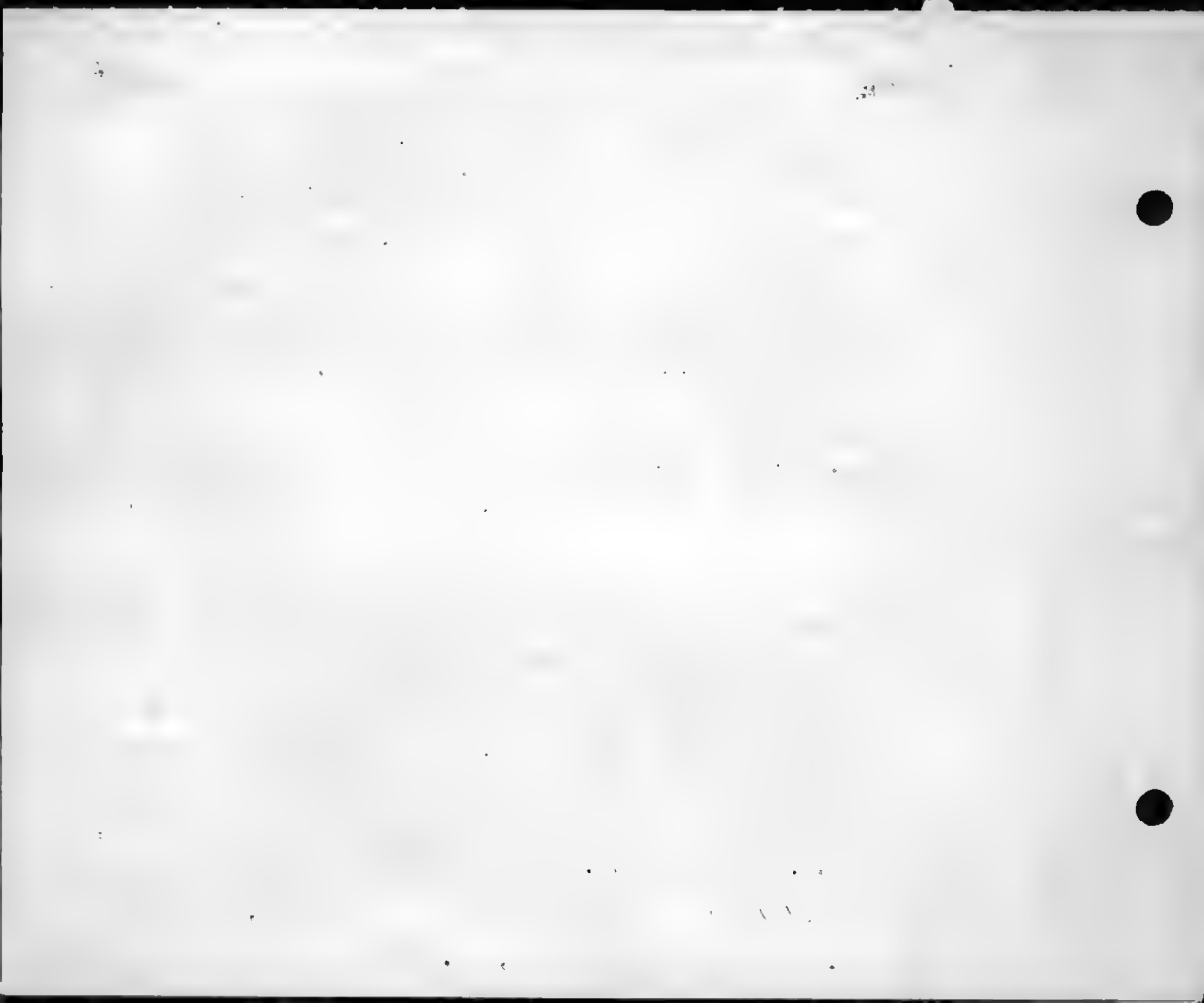
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04415

CERTIFICATE OF DEATH

04417

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Princess Anne	
c. LENGTH OF STAY IN 1b since 11/7/66		d. STREET ADDRESS Route 1, Box 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ORVAL GUY SANDERS		4. DATE OF DEATH Month Day Year March 4 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/1918
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Granville Sanders		14. MOTHER'S MAIDEN NAME Amanda Macon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes W. War II		16. SOCIAL SECURITY NO 219-07-4360	
17. INFORMANT Records of Pine Bluff Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO (b) (c) Cond'tions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/7 , 19 66 , to 3/4 , 19 67 , that (I) (we) last saw the deceased alive on 3/4/19 67 , and that death occurred on 4:15am , from causes and on the date stated above.			
22a. SIGNATURE E.P. Ritchings		22b. DATE SIGNED March 4, 1967	
22c. PHYSICIAN'S NAME (Type) E.P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3/6/1967	23c. NAME OF CEMETERY OR CREMATORY QUINTON CEMETERY	23d. LOCATION (City or Town) (County) (State) COSTON, MARYLAND
24. FUNERAL DIRECTOR LEVIN R. WILSON		25a. REC'D BY REGISTRAR PRINCESS ANNE, MD.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 8 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

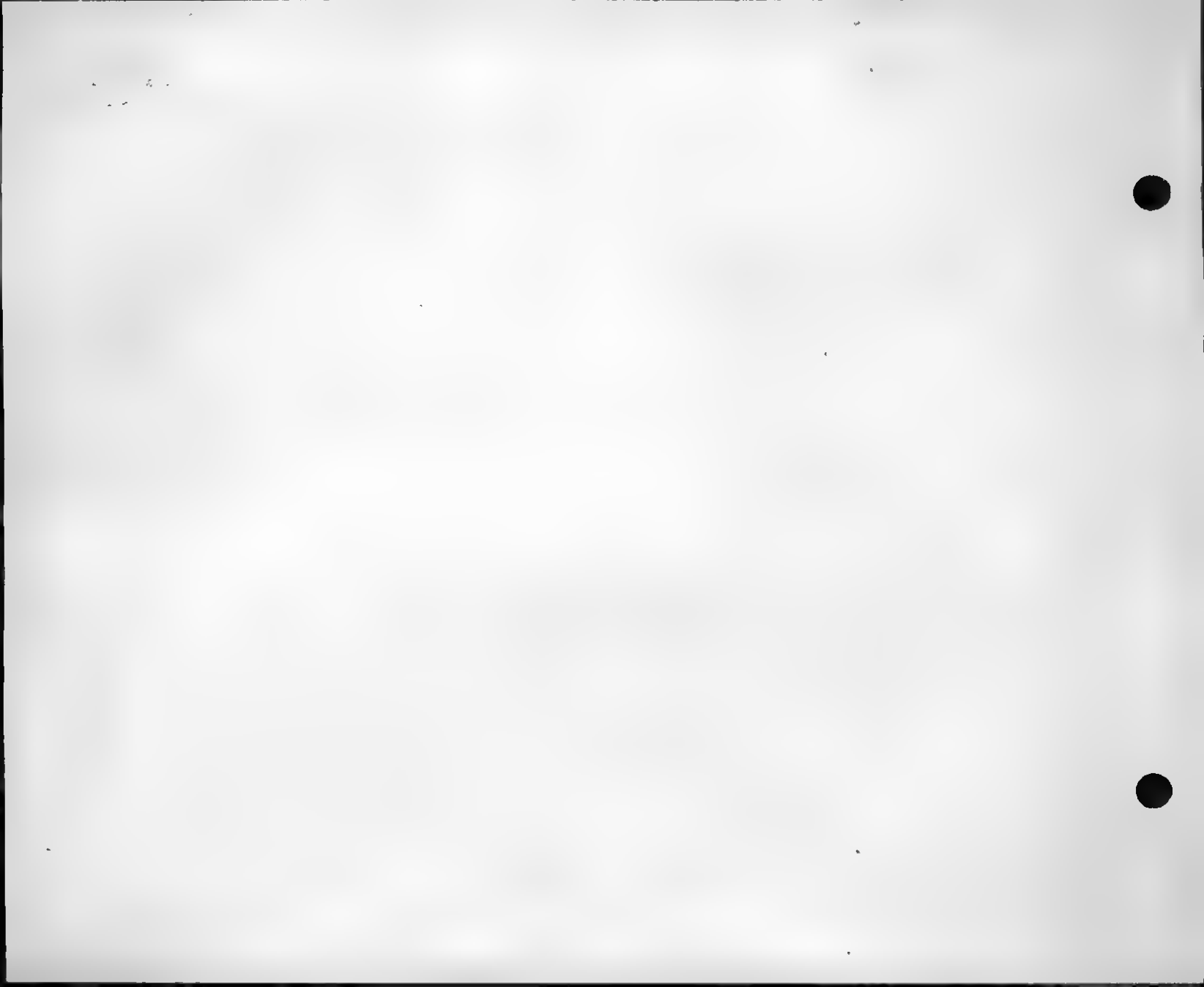
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04416

04418

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE Md b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS RD # 3	
3 NAME OF DECEASED (Type or print) First Edward Middle Paul Last Schultz		4 DATE OF DEATH Month March Day 25 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH APRIL 24, 1911
9 AGE (In years last birthday) 55 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELL DRILLER	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PA.	
12. CIT ZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Edward Schultz	
14. MOTHER'S MAIDEN NAME MARY TIMARDI		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Complication of gall bladder with 1551 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) metastasis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hodgkins Disease			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-13-67 , 19 67 to 3-25-67 , 19 67 that (I) (we) last saw the deceased alive on 3-25-1967 , and that death occurred at 5:28 PM , from causes on and on the date stated above.			
22a. SIGNATURE James E. Cappel M.D.		22b. DATE SIGNED 3-28-67	
22c. PHYSICIAN'S NAME (Type) James E. Cappel		22d. ADDRESS Medical Center Salisbury Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3/28/67	23c. NAME OF CEMETERY OR CREMATORY Smith Mills	23d. LOCATION (City or Town) (County) (State) Delmar SUSSEX DE
24. FUNERAL DIRECTOR William M. Morrey		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE MAR 30 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

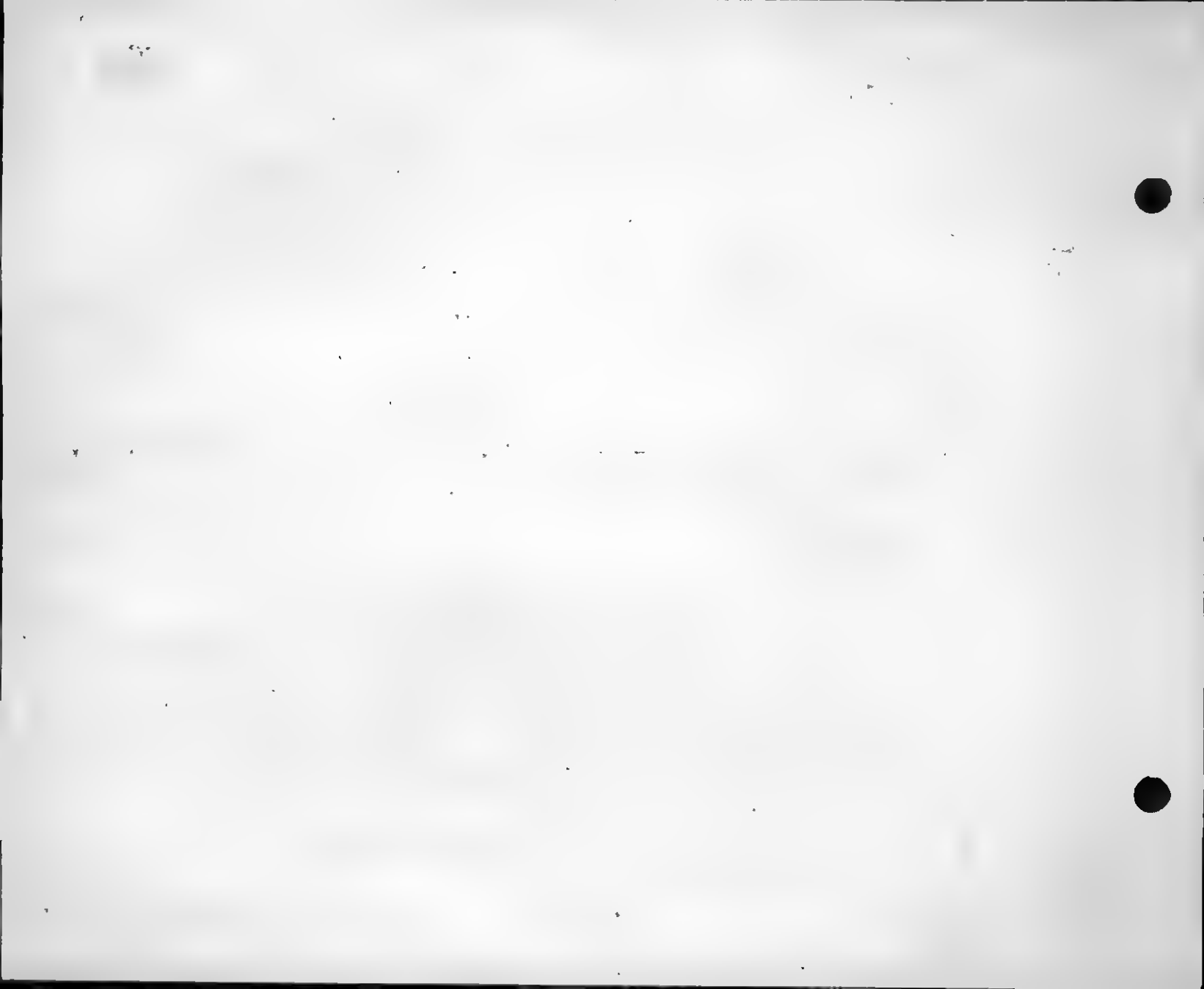
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04417

CERTIFICATE OF DEATH

04419

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greenwood</u> 463			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3 NAME OF DECEASED (Type or print) <u>Laura May Sharp</u>				4 DATE OF DEATH <u>March 22</u> 19 <u>67</u>			
5 SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 15, 1902</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Buckalew</u>		14. MOTHER'S MAIDEN NAME <u>Maude Elizabeth Howard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>221-05-3209</u>		17. INFORMANT Address <u>Mr. Jesse Sharp Greenwood, Del.</u>			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> 4000 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-22</u> , 19 <u>67</u> , to <u>3-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-22</u> , 19 <u>67</u> , and that death occurred at <u>10 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W. R. Ellis</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. R. Ellis</u>				22d. ADDRESS <u>Medical Bldg. Salisbury, Md.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johnstown</u>		23d. LOCATION (City or Town) (County) (State) <u>Greenwood Sussex Del.</u>	
24. FUNERAL DIRECTOR <u>Lewis D. McKnatt</u>				ADDRESS <u>HARRINGTON, Del.</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 29 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

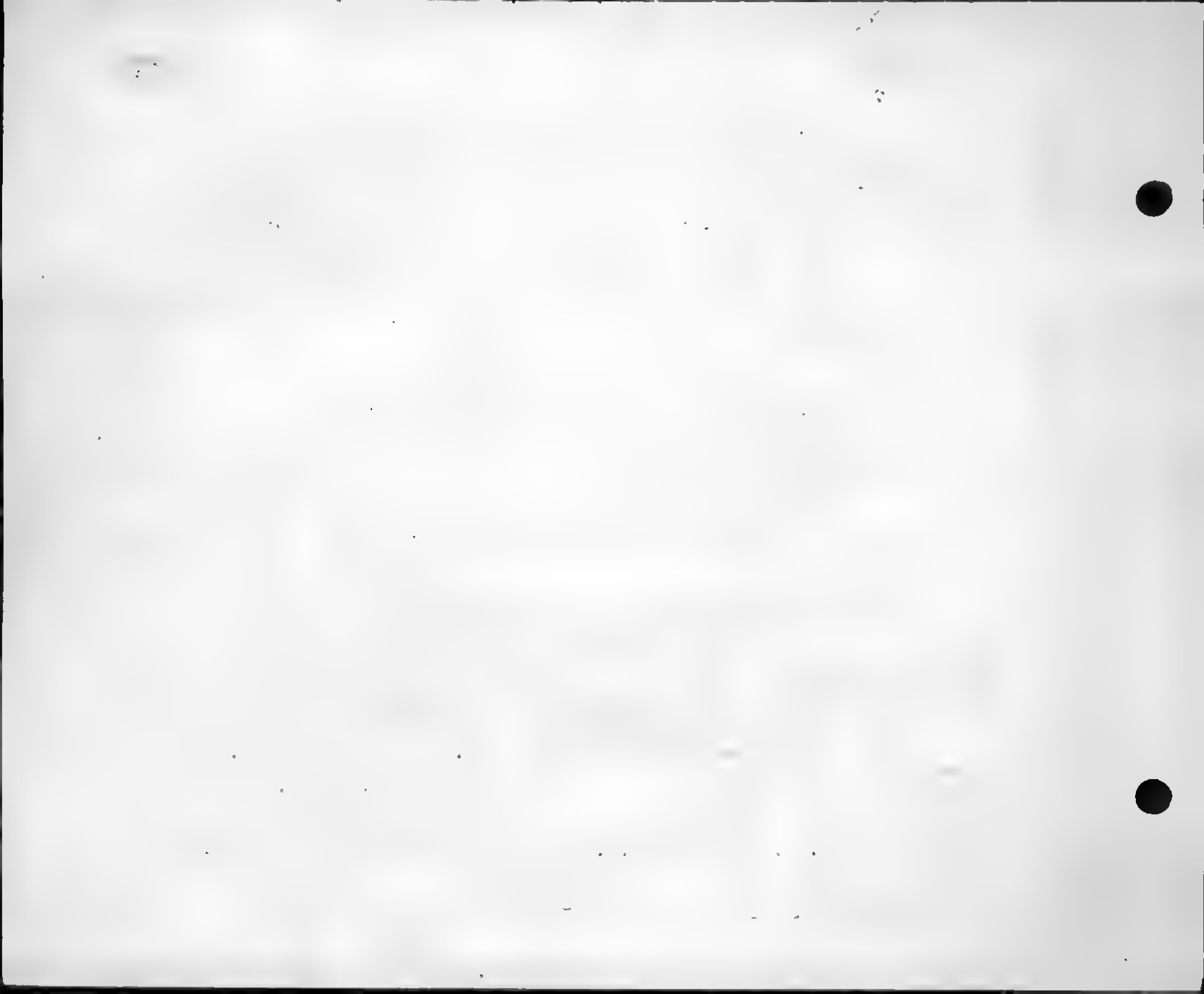
04418

CERTIFICATE OF DEATH

04420

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN TB 410 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Grace Middle Lucille Last Smith		4. DATE OF DEATH Month March Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1898
9. AGE (In years lost birthday) 68 yrs		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own H me	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sheraton		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Elton I. Smith, Snow Hill, Md.		18. ADDRESS 240 Martin St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Multiple pulmonary emboli 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchopneumonia - aspiration (c)			INTERVAL BETWEEN ONSET AND DEATH few hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1966 , to Mar. 26, 1967 , that (I) (we) last saw the deceased alive on March 26, 19 67 , and that death occurred at 1:25 P.M. M. from causes and on the date stated above.			
22a. SIGNATURE <i>A. C. Mitchell</i>		22b. DATE SIGNED 3/27/67	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M.D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-28-1967	23c. NAME OF CEMETERY OR CREMATORY Union-Greenbackville	23d. LOCATION (City or Town) (County) (State) Worcester, Maryland
24. FUNERAL DIRECTOR <i>Qualis Funeral</i>		25a. REC'D BY REGISTRAR MAR 29 1967	
ADDRESS Snow Hill Md.		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04419

CERTIFICATE OF DEATH

04421

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN IB 5452 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS UNK.	
3. NAME OF DECEASED (Type or print) First Walter Middle SPIVEY Last SPIVEY		4. DATE OF DEATH Month March Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1893
9. AGE (In years last birthday) 73 yrs.		10. KIND OF BUSINESS OR INDUSTRY UNK.	
11. BIRTHPLACE (County & State, or foreign country) Wakefield, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK.		14. MOTHER'S MAIDEN NAME UNK.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes		16. SOCIAL SECURITY NO. UNK.	
17. INFORMANT Hospital Records		Address VAH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) Bronchopneumonia DUE TO (c) 7 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic bronchitis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 31 , 19 67 , to March 5 , 19 67 , that (I) (we) last saw the deceased alive on March 5 , 19 67 , and that death occurred at 2:55 AM , from causes and on the date stated above.			
22a. SIGNATURE C. H. Winnacott		22b. DATE SIGNED 3-6-67	
22c. PHYSICIAN'S NAME (Type) Dr. C. H. Winnacott		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-10-67	23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem	23d. LOCATION (City or Town) (County) (State) Baltimore Md
24. FUNERAL DIRECTOR Moison & Fyett Funeral Home		25a. REC'D BY REGISTRAR Charles Yager	
25b. REGISTRAR'S SIGNATURE Charles Yager		DATE MAR 9 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

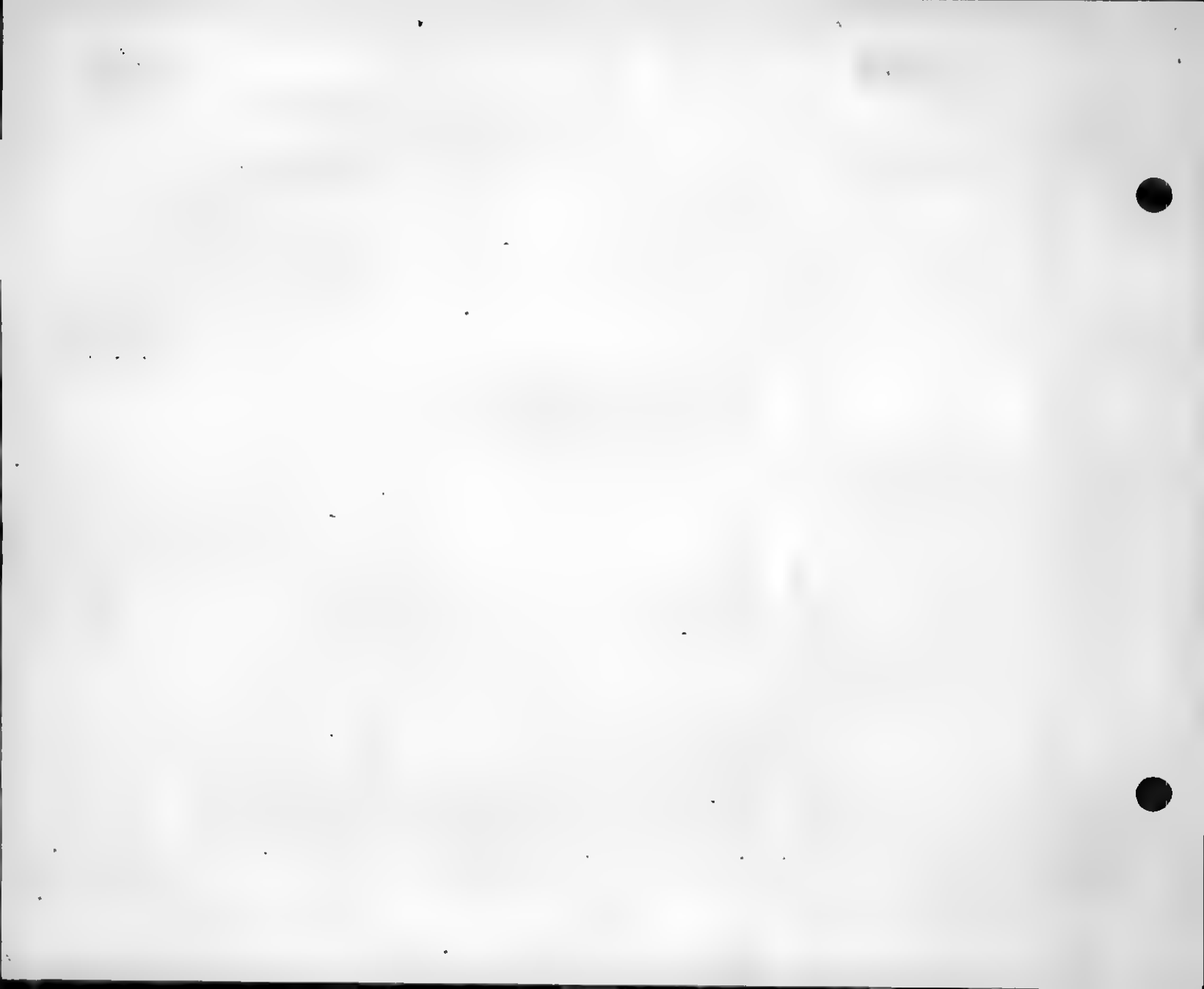
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04420

CERTIFICATE OF DEATH

04422

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 325 Winter Quarters Drive	
3. NAME OF DECEASED (Type or print) BEATRICE CANNON STEVENSON		4. DATE OF DEATH Month March Day 7 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1893
9. AGE (In years last birthday) 73 yrs		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Banking	
11. BIRTHPLACE (County & State, or foreign country) Worcester County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Edison Stevenson		14. MOTHER'S MAIDEN NAME Elizabeth Hearne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-12-1841	
17. INFORMANT Miss Hilda Stevenson, Pocomoke City, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Artery Thrombosis DUE TO (c) 2 days		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive Heart Failure - Pulmonary Emboli		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/5/1967 to 3/7/1967 that (I) (we) last saw the deceased alive on 3/7/1967 and that death occurred at 11:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE O. J. BURTON, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Medical Center, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-10-1967	23c. NAME OF CEMETERY OR CREMATORY Presbyterian	23d. LOCATION (City or Town) (County) (State) Pocomoke City Wor. Md.
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR MAR 13 1967	
ADDRESS Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/67

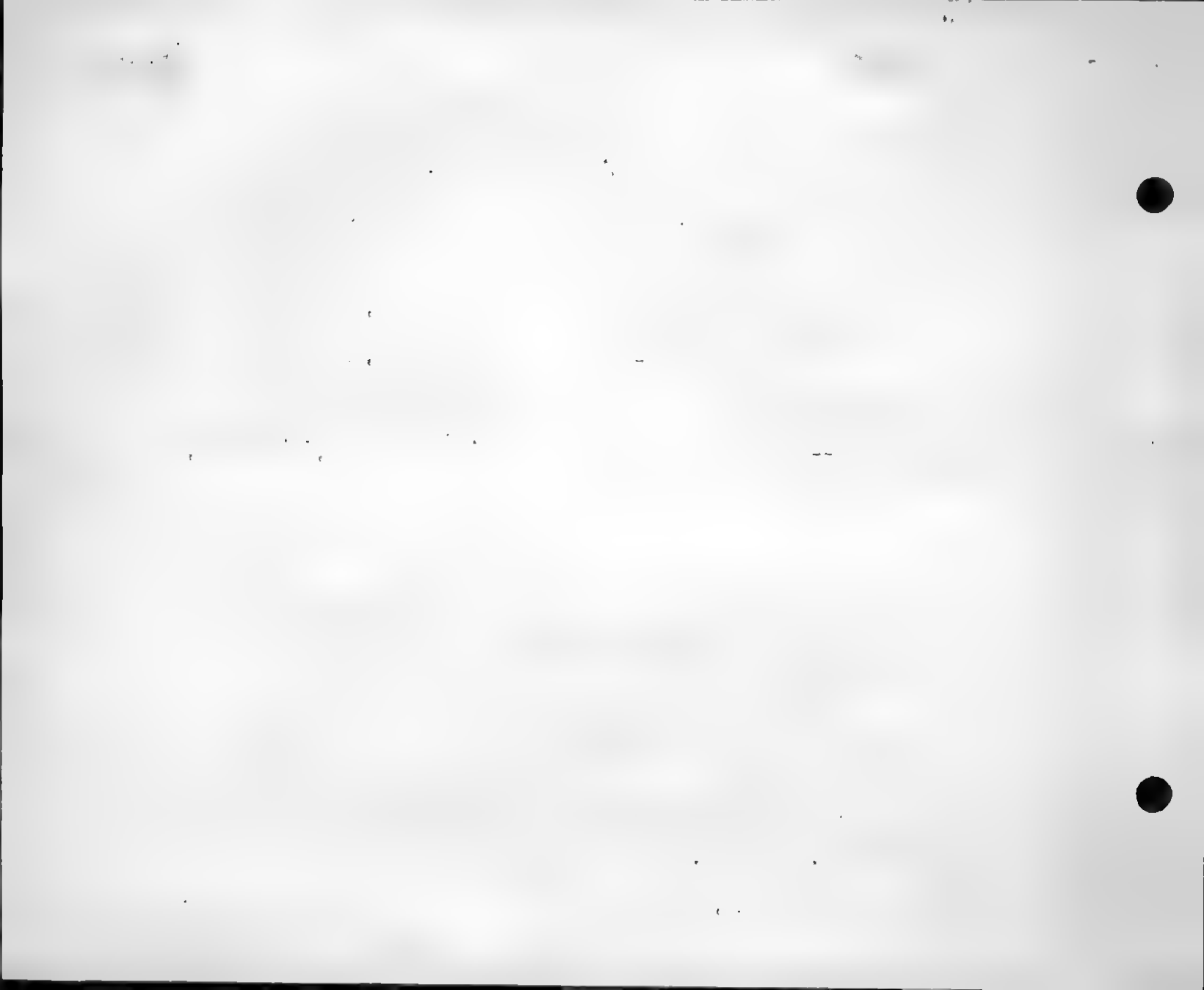
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04421

CERTIFICATE OF DEATH

04423

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b Adm. in 1b 2/4/67			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 315 Penn Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Connie ELLEN Stevenson				4. DATE OF DEATH Month Day Year March 7 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 13, 1967	
9. AGE (In years lost birthday) yrs 0		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Robert Lee Stevenson			
14. MOTHER'S MAIDEN NAME Patricia Ellen Powell				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no --			
16. SOCIAL SECURITY NO. ---				17. INFORMANT Address Mr. Robert Lee Stevenson 315 Penn Street, Salisbury, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Diffuse Pneumonia - Right lung 7630 DUE TO (b) approx 4 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patent Ductus Arteriosus							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/4 , 19 67 to 3/7 , 19 67 , that (II) (we) last saw the deceased alive on 3/7 , 19 67 , and that death occurred at 12:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Alfred C Kolls				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/8/67	
22c. PHYSICIAN'S NAME (Type) Dr. Alfred C. Kolls				22d. ADDRESS Medical Center Salisbury Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 10, 1967		23c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		23d. LOCATION (City or Town) (County) (State) Worcester Co., Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR MAR 9 1967		25b. REGISTRAR'S SIGNATURE J. J. J. J.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05968

04422

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>25 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> d. STREET ADDRESS <u>137 Delaware Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOSHA C. SWEAT</u>				4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 31, 1908</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NORFOLK, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>718-10-8088</u>			
17. INFORMANT <u>Lillian Sweet</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> CONDITIONS, if any, which gave rise to immediate cause (b) <u>congestive failure</u> cause last, (c) <u>Generalized arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21. I certify that (I) (this hospital) attended the deceased from <u>9 Mar 1967</u> to <u>23 Mar 1967</u> that (I) (we) last saw the deceased alive on <u>23 Mar 1967</u> and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.				22. SIGNATURE <u>F. A. Farnell</u> M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5-27-67</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>West Funeral Home</u>				25a. REC'D BY REGISTRAR <u>APR 12 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

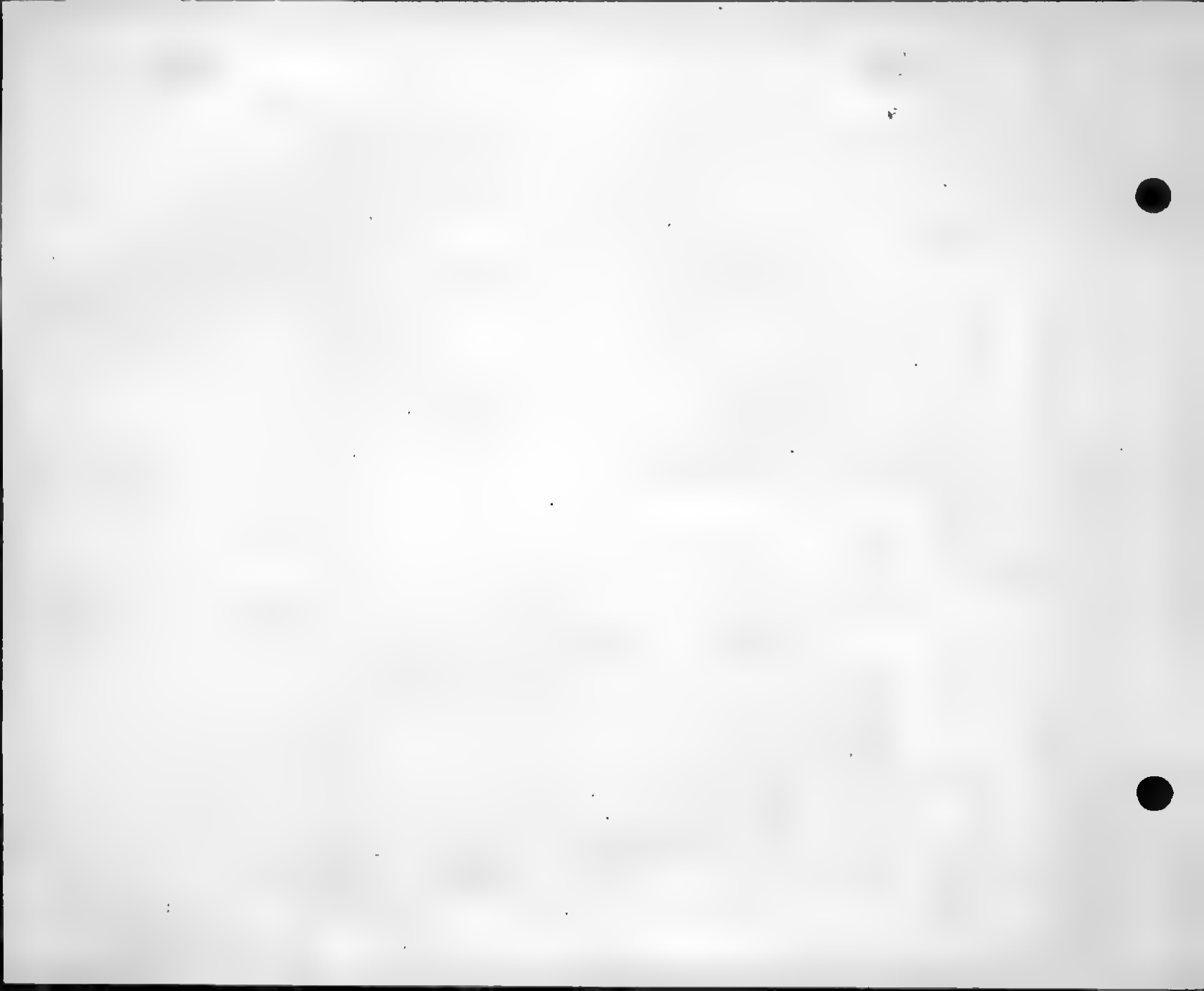
MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04423

CERTIFICATE OF DEATH

04424

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Rural Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>RFD #2</u>	
3. NAME OF DECEASED (Type or print) First <u>Bobby</u> Middle <u>Girl (Nina)</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 9 1967</u>
9. AGE (In years lost birthday) yrs. <u>44</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Clarence Robins</u>	
14. MOTHER'S MAIDEN NAME <u>Cerinda Taylor</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Clarence Robins, Snow Hill, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO <u>Prematurity (wt 1245 gms)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>None</u> (c) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>about 44 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/9</u> , 19 <u>67</u> , to <u>3/11</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>3/10</u> , 19 <u>67</u> , and that death occurred at <u>9:52</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Arthur C. Holls</u> M.D.		22b. DATE SIGNED <u>3/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Arthur C. Holls</u>		22d. ADDRESS <u>Medical Center Salisbury Maryland</u>	
23a. BURIAL, CREMATION, DEMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar 13, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Maryland</u>	
24. FUNERAL DIRECTOR <u>Thomas J. Allen</u>		25a. REC'D BY REGISTRAR DATE <u>13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

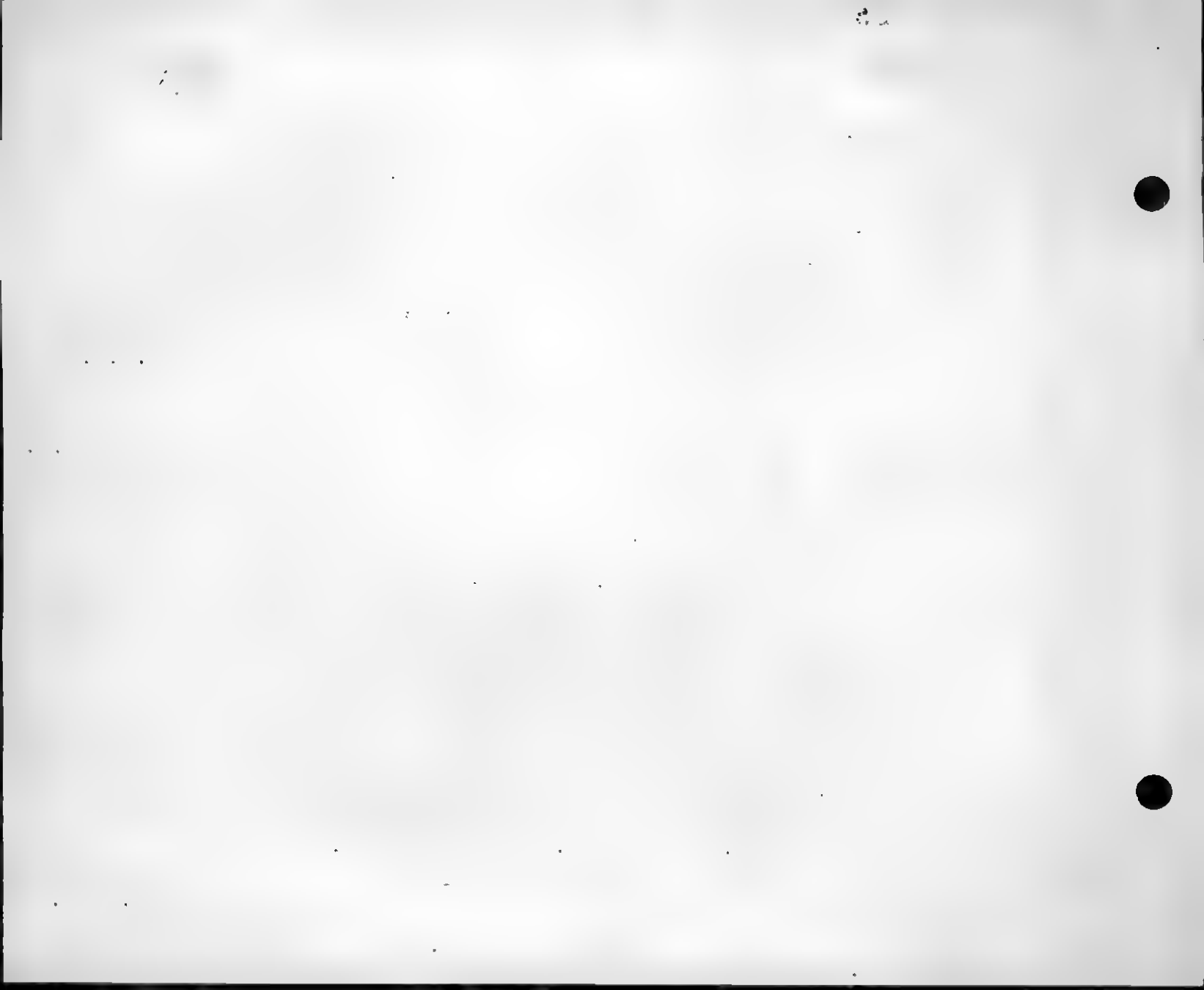
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04424

CERTIFICATE OF DEATH

04425

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b 1 day	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		d. STREET ADDRESS ---	
3 NAME OF DECEASED (Type or print) First Middle Last Bessie Elizabeth Timmons		4. DATE OF DEATH Month Day Year March 21 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 1, 1888
9. AGE (In years last birthday) 78 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --
11. BIRTHPLACE (County & State or foreign country) Worcester County, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joshua Davis		14. MOTHER'S MAIDEN NAME Sallie Merritt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-22-4735	
17. INFORMANT Mrs William Wittman, Binghamton, N.Y.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) CARDIAC FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 5-9 R 1 YR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTHRITIS			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from FEB 1 , 19 67 , to MARCH 21 , 19 67 , that (I) (we) last saw the deceased alive on MARCH 20 , 19 67 , and that death occurred at 2:57 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert C. LaMar		22b. DATE SIGNED 3/21/67	
22c. PHYSICIAN'S NAME (Type) Robert C. LaMar, M.D.		22d. ADDRESS 104 Bay St., Snow Hill, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-24-1967	23c. NAME OF CEMETERY Porterville Methodist	23d. LOCATION (City or Town) (County) (State) Stockton, Wor. Md.
24. FUNERAL DIRECTOR Robert H. Watson		25a. REC'D BY REGISTRAR DATE MAR 27 1967	
ADDRESS Pocomoke City, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04425

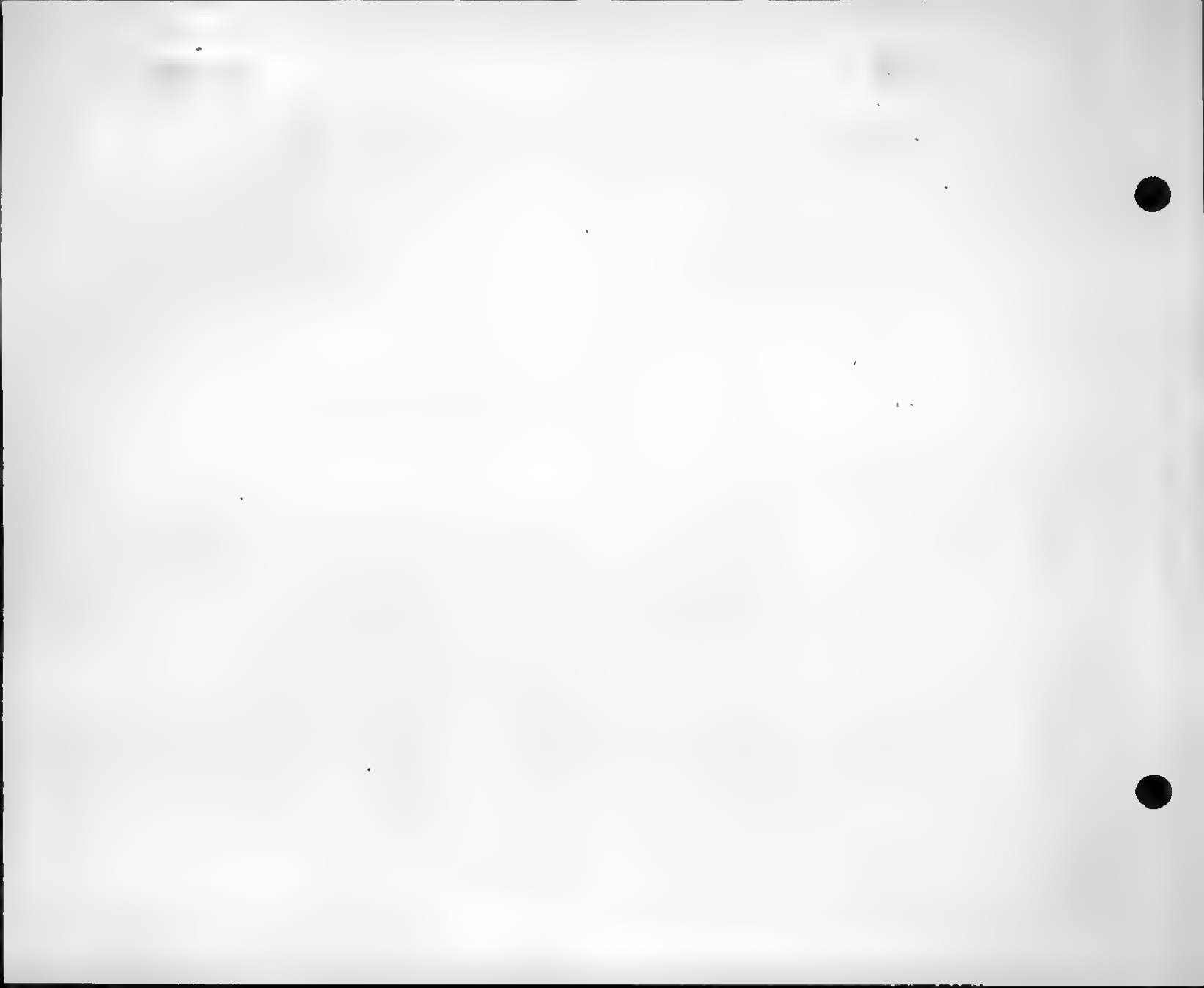
CERTIFICATE OF DEATH

04426

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 9 POWELLTON AVE	
3 NAME OF DECEASED (Type or print) LULA First Middle Last Todd		4. DATE OF DEATH Month March Day 22 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-21-1918
9. AGE (In years lost birthday) 49 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAIRDRESSER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ELIHO G. JOHNSON		14. MOTHER'S MAIDEN NAME LAURA TAYLOR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BRENDA WILLIAMS		Address BERLIN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of cervix - widespread metastasis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at 12:30 P.M., from causes and on the date stated above.			
22a. SIGNATURE Norma Williams		22b. DATE SIGNED 3-23-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 3-25-67	23c. NAME OF CEMETERY OR CREMATORY SUNSET MEM. PK.	23d. LOCATION (City or Town) (County) (State) BERLIN, WOR. MD.
24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME		25. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

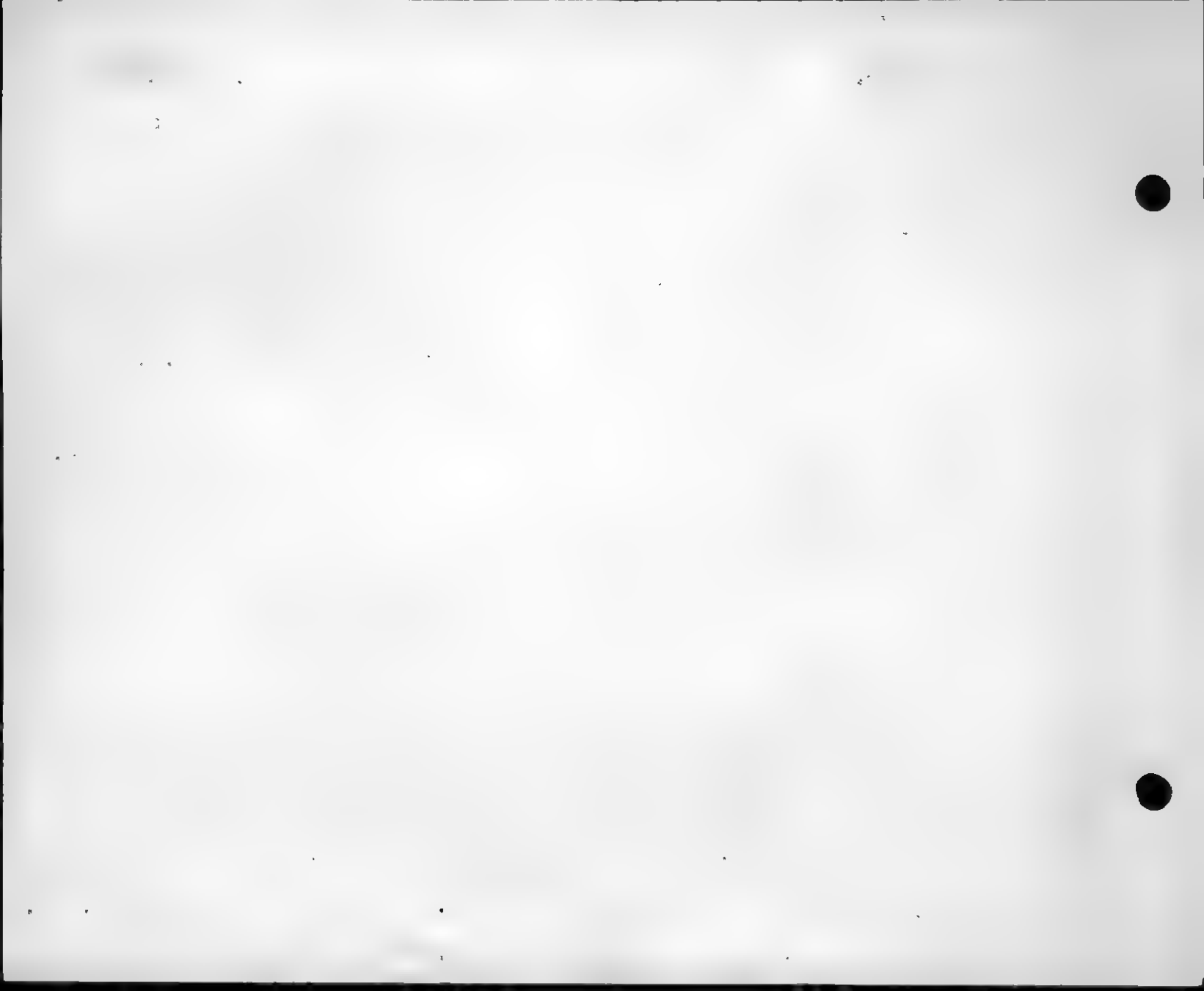
Item #9 Film #3357 3/30/67 pc

04426

CERTIFICATE OF DEATH

04427

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Selbyville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Helen Townsend		4. DATE OF DEATH Month Day Year MARCH 23 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/16/1919
9. AGE (In years last birthday) 47 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Worcester, Maryland U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clarence Harman		14. MOTHER'S MAIDEN NAME Althea Collick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-12-5626	
17. INFORMANT Norman Townsend		Address Selbyville, Dela.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) longshorement fracture DUE TO (b) Ca Cx stage IV DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1405
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/15, 1967 to 3/22, 1967 , that (I) (we) last saw the deceased alive on 3/22 19 67 , and that death occurred at 1:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Stedman W. Smith		22b. DATE SIGNED 3/23/67	
22c. PHYSICIAN'S NAME (Type) Stedman W. Smith		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3/27/1967	23c. NAME OF CEMETERY OR CREMATORY Coolspring Cem.	23d. LOCATION (City or Town) (County) (State) Girdletree, Worces. Md.
24. FUNERAL DIRECTOR Richard T. Watson		25a. REC'D BY REGISTRAR MAR 27 1967	
ADDRESS Selbyville, Dela.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



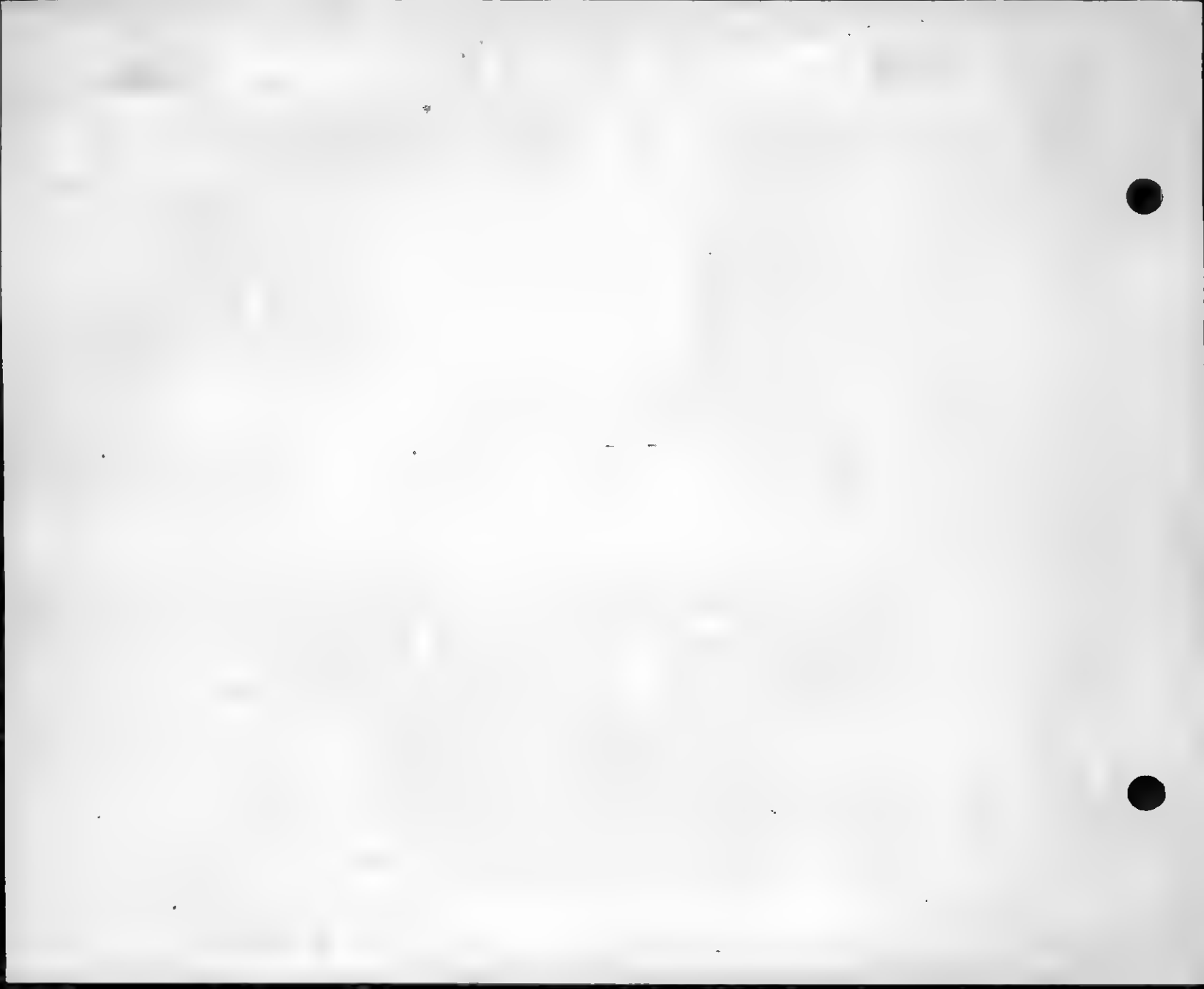
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04427 CERTIFICATE OF DEATH 04428											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 14 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) XX						2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS Zion Church Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Edward Middle Truitt Last Truitt						4. DATE OF DEATH Month March Day 2 Year 1967					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 7, 1889		9. AGE (in years last birthday) 77 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Poultryman				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Sampson Edward Truitt						14. MOTHER'S MAIDEN NAME Alice Powell					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX				16. SOCIAL SECURITY NO. 217-36-1164		17. INFORMANT Ester H. Truitt Salisbury, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1810 Carcinoma of urinary bladder with metastases to lungs DUE TO (b) 1 year DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/14, 1956 , to death , 19 67 , that (I) (we) last saw the deceased alive on Mar 2 19 67 , and that death occurred at 4:57 PM , from the causes and on the date stated above.											
22a. SIGNATURE Ernest Larmore						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3/4/67			
22c. PHYSICIAN'S NAME (Type) ERNEST LARMORE						22d. ADDRESS Delmar, Del.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 3/5/67		23c. NAME OF CEMETERY OR CREMATORY Lewis				23d. LOCATION (City, town or county) (State) Willards, Md.			
24. FUNERAL DIRECTOR Peter Whaley Salisbury, Del. ADDRESS						25a. REC'D BY REGISTRAR Charles J. Jones DATE MAR 7 1967		25b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

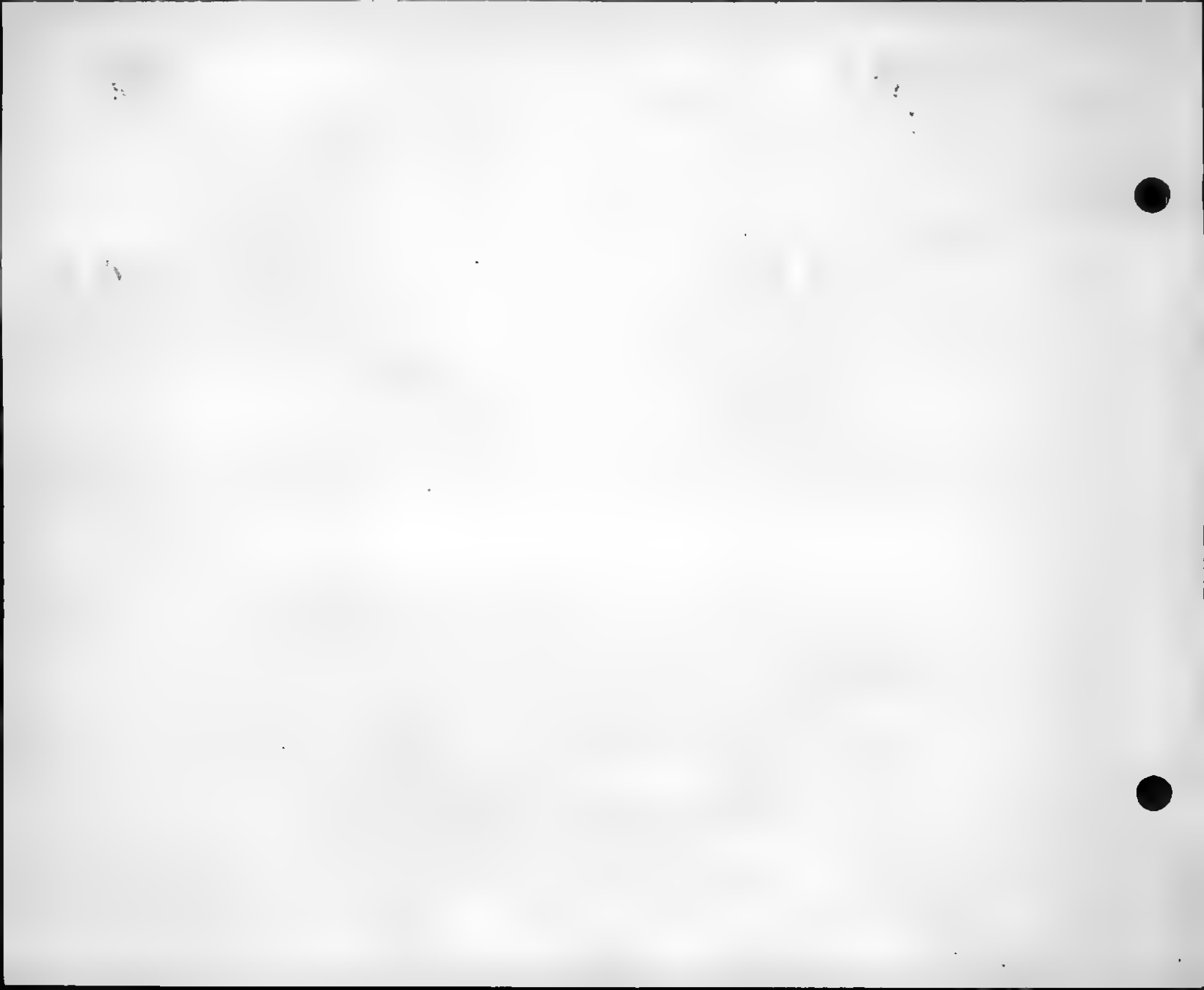
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04428

CERTIFICATE OF DEATH

04429

1. PLACE OF DEATH a. COUNTY: <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE: <u>Maryland</u> b. COUNTY: <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>2100</u>	
3. NAME OF DECEASED (Type or print) First: <u>LELIA</u> Middle: <u>TULL</u> Last: <u>TULL</u>		4. DATE OF DEATH Month: <u>MARCH</u> Day: <u>20</u> Year: <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9 1888</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. IF UNDER 1 YEAR: Months: <u>0</u> Days: <u>0</u> Hours: <u>0</u> Min: <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Tull</u>		14. MOTHER'S MAIDEN NAME <u>Sarah (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Matherine Armstrong</u>		Address <u>4033 Spring Garden St. Phila. Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO (b) <u>A.S.C.V.D.</u> DUE TO (c) <u>Diabetes - mild - untreated</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes - mild - untreated</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-20-67</u> , 19 <u>67</u> , to <u>3-20-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3-20-67</u> , 19 <u>67</u> , and that death occurred at <u>9:30</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph C. Fitzgerald, M.D.</u>		22b. DATE SIGNED <u>3/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Medical Center</u>		22d. ADDRESS <u>Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Mar. 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	23d. LOCATION (City or Town) (County) (State) <u>Snow Hill Maryland</u>
24. FUNERAL DIRECTOR <u>William F. Morris, Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 29 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04429

CERTIFICATE OF DEATH

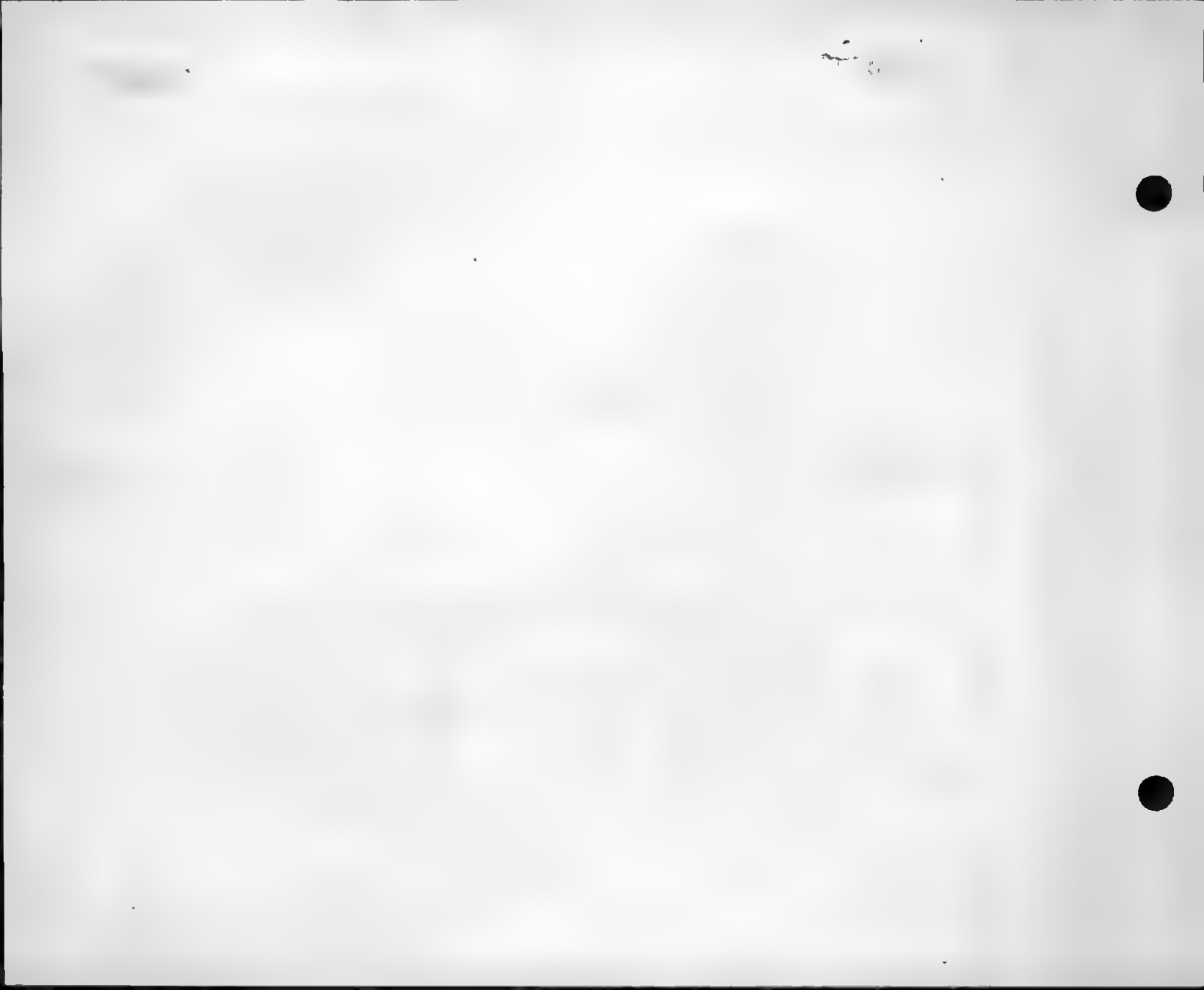
04430

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <u>MD</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u> d. STREET ADDRESS <u>6650 Collinsdale Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Ruth Middle (ULRICH) Last Ulrich</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 23 01.</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OVERSEER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MD.</u>	
12. CITIZEN OF WHAT COUNTRY? 		13. FATHER'S NAME <u>PETER KLINGELHOFFER</u>	
14. MOTHER'S MAIDEN NAME <u>Amalia WOLF</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 		17. INFORMANT Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>Unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>3/25/67</u> <u>BALTO.</u> <u>MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>3/25/67</u> to <u>3/25/67</u> that (I) (we) last saw the deceased alive on <u>3/25/67</u> and that death occurred at <u>9:45</u> M, from causes and on the date stated above.		
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) 		22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/29/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>
24. FUNERAL DIRECTOR <u>Charles A. Heumann</u>		25a. REC'D BY REGISTRAR <u>MAR 31 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

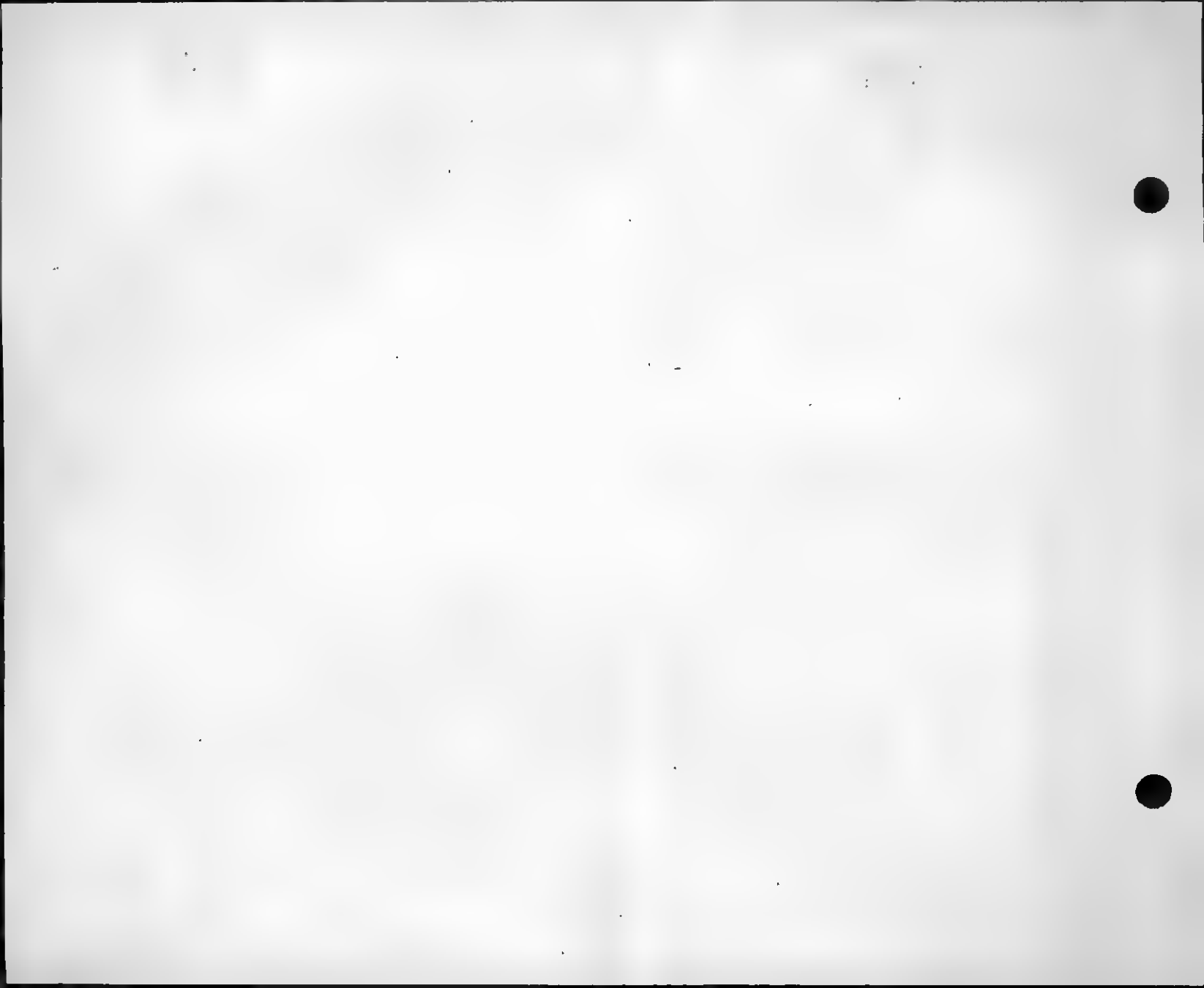
MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

04430

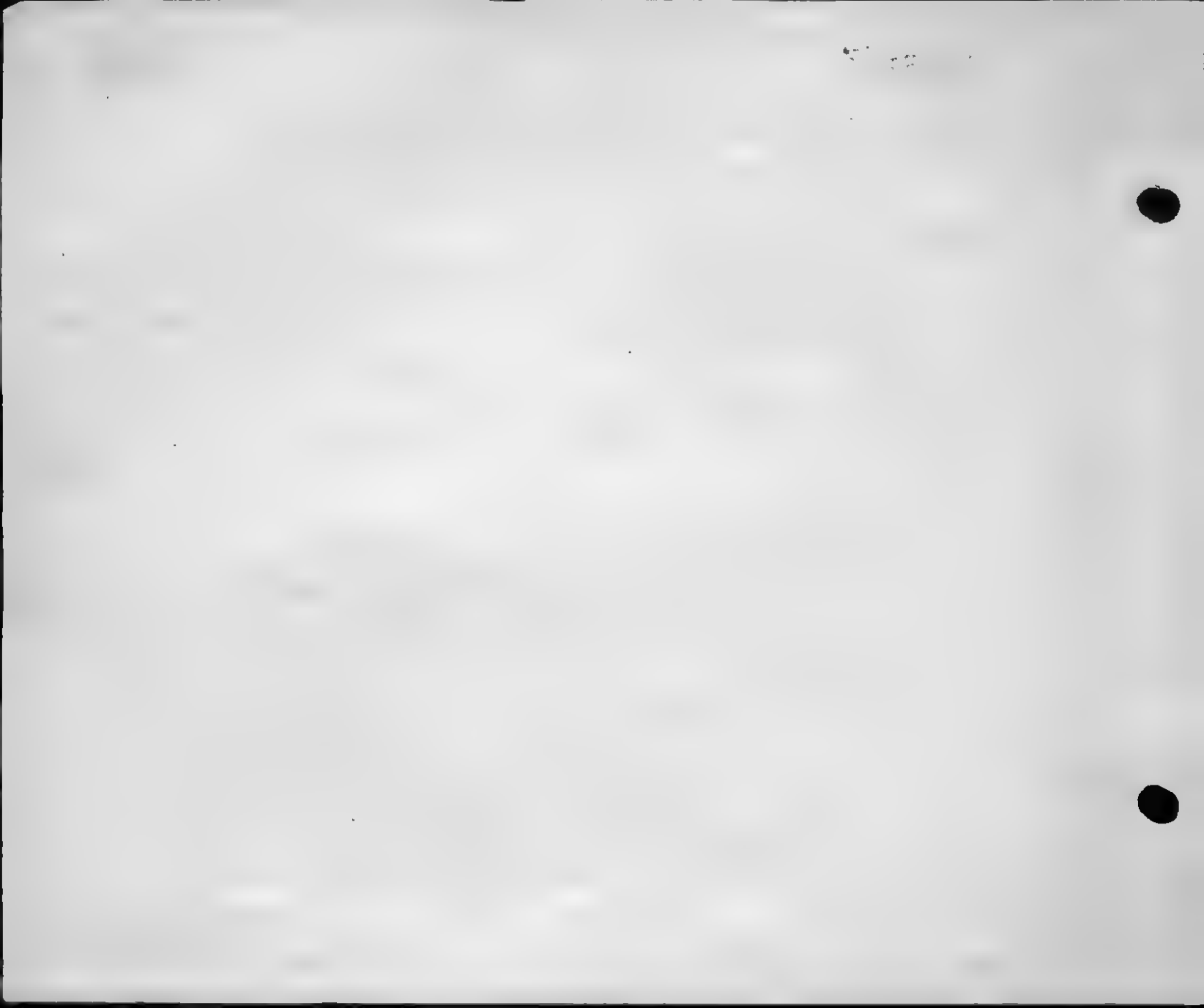
04431

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY		e. 5 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last Annie B. Wainwright				4. DATE OF DEATH Month Day Year March 21 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 25 1902	9. AGE (In years last birthday) 64 yrs	10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE TAYLOR				14. MOTHER'S MAIDEN NAME ALICE FAY MCCABE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Hilda Ruth Ocean at Md Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arterial Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH 22 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 20, 1967 to Mar. 21, 1967 , that (I) (we) last saw the deceased alive on Mar. 21, 1967 , and that death occurred at 7:50 M, from causes and on the date stated above.							
22a. SIGNATURE Alan J. Salzman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 3/23/67		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR MD	
24. FUNERAL DIRECTOR Anna R. Burkage Berlin Md ADDRESS				25a. REC'D BY REGISTRAR MAR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04431						04432					
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>					
c. LENGTH OF STAY IN TB <u>30 yrs</u>						d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
<u>Samuel</u>			<u>Warfield</u>			<u>3 - 15</u>			<u>1967</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/6/1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days	
										11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Seafood</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Samuel Warfield</u>						14. MOTHER'S MAIDEN NAME					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes World War I</u>						16. SOCIAL SECURITY NO. <u>215-18-4956</u>					
17. INFORMANT <u>Stella Holbrook, Nanticoke, Md.</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Car accident of Deceased</u>											
1810 DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
(a), stating the underlying cause last. DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
Hour a.m. p.m. 19			While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>								
21. I certify that (I) (this hospital) attended the deceased from..... 19....., to..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 230 A.M., from the causes and on the date stated above.											
22a. SIGNATURE <u>N. W. Todd</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>N. W. Todd</u>						22d. ADDRESS <u>Med. Comm. Nanticoke, Md.</u>					
23a. BURIAL, CREMATION, or other disposal (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)		
<u>Burial</u>			<u>3/19/67</u>			<u>Nanticoke Cem.</u>			<u>Nanticoke, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. W. Smith, Biverville, Md.</u>						25a. REC'D BY REGISTRAR <u>MAR 27 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



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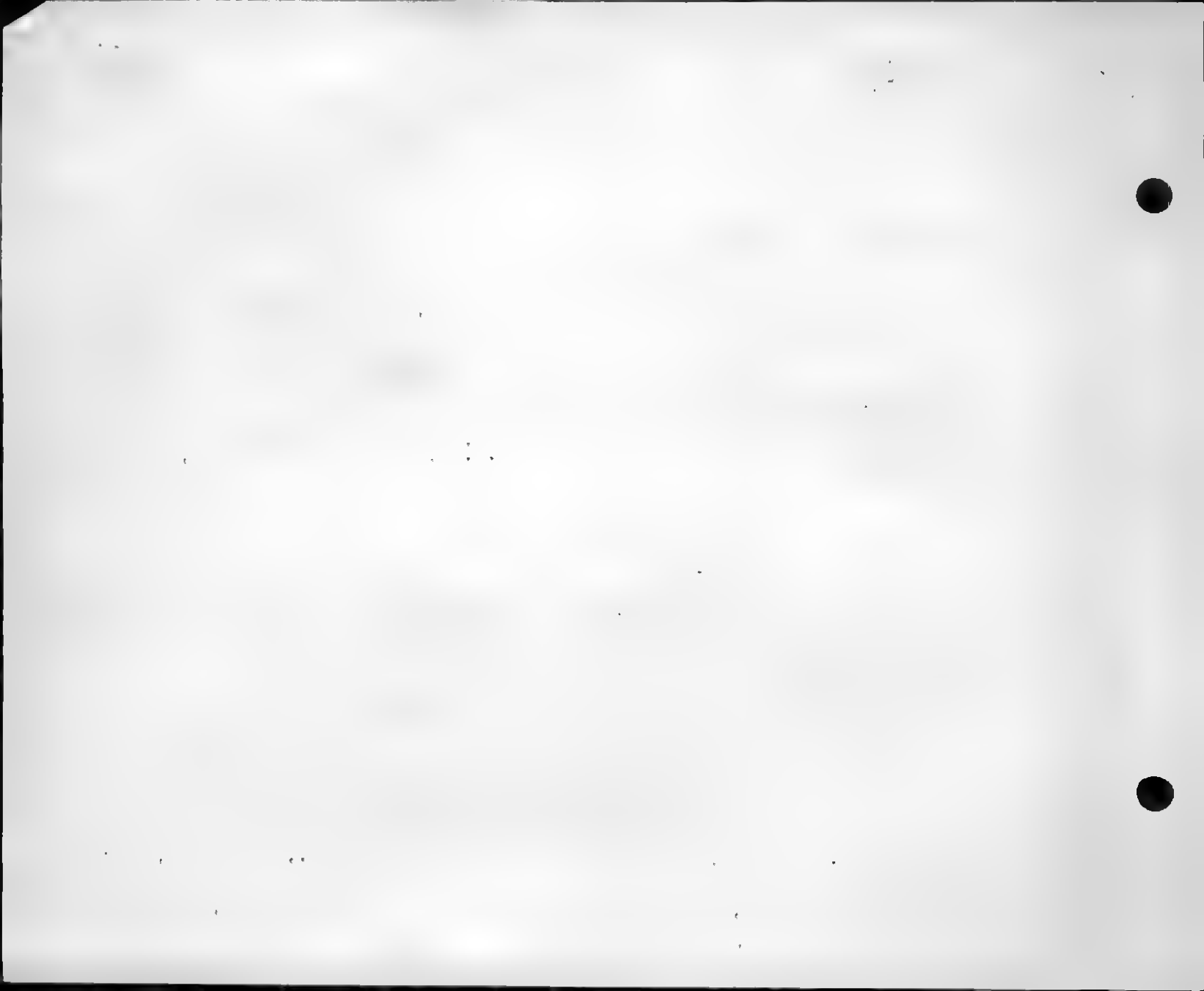
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04432

CERTIFICATE OF DEATH

04433

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 613 Church Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EBEN				4. DATE OF DEATH Month Day Year June 29, 1967				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 29, 1904	9. AGE (in years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min 0 4		IF UNDER 24 HRS. Hours Min 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County, State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Harry Vincent Welch				14. MOTHER'S MAIDEN NAME Bertha Ellison				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Rebecca Bradford (Daughter) R.D.#3, Box 157M, Bradenton, Florida 33505				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe bilateral pneumonia DUE TO (b) Chronic bronchitis DUE TO (c) Chronic lymphatic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH Days Days years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Rheumatic Heart disease with congestive failure							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept 22, 1966 , to March 3, 1967 , that (I) (we) last saw the deceased alive on March 3, 1967 , and that death occurred at 12:40 AM , from causes and on the date stated above.								
22a. SIGNATURE Thomas P. Bigbee M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED March 3, 1967		
22c. PHYSICIAN'S NAME (Type) Dr. Thomas P. Bigbee				22d. ADDRESS Maryland Ave., Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR MAR 9 1967		25b. REGISTRAR'S SIGNATURE [Signature]		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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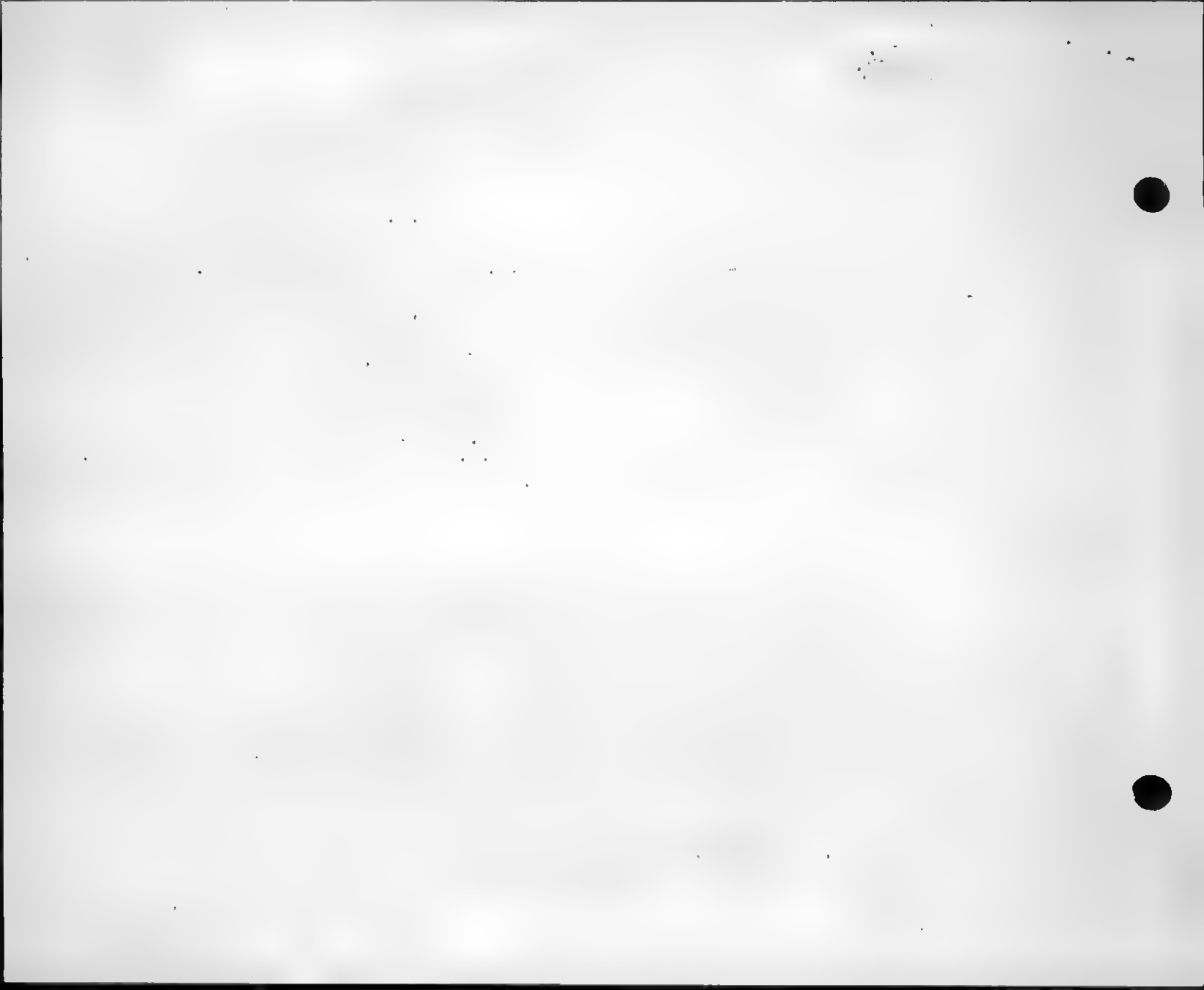
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04433

CERTIFICATE OF DEATH

04434

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS R.D.#3, AirPort Road	
3 NAME OF DECEASED (Type or print) (Baby) First Middle Last White		4. DATE OF DEATH Month Day Year MARCH 19 1967	
5 SEX FEMALE	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1967
9. AGE (In years last birthday) 0 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min 0 0 17 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ronald Lee White		14. MOTHER'S MAIDEN NAME Sandra Sue Vickers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Ronald Lee White (Father)		Address R.D.#3, AirPort Road, Salisbury, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart attack DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/18, 1967 to 3/19, 1967 that (I) (we) last saw the deceased alive on 3/19, 1967 , and that death occurred at 10:00 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. William B. Smith M.D.		22b. DATE SIGNED 3/19/67	
22c. PHYSICIAN'S NAME (Type) Dr. William B. Smith		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF March 22, 1967	23c. NAME OF CEMETERY OR CREMATORY Whaylesville Cemetery	23d. LOCATION (City or Town) (County) (State) Worcester Co., Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR MAR 21 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



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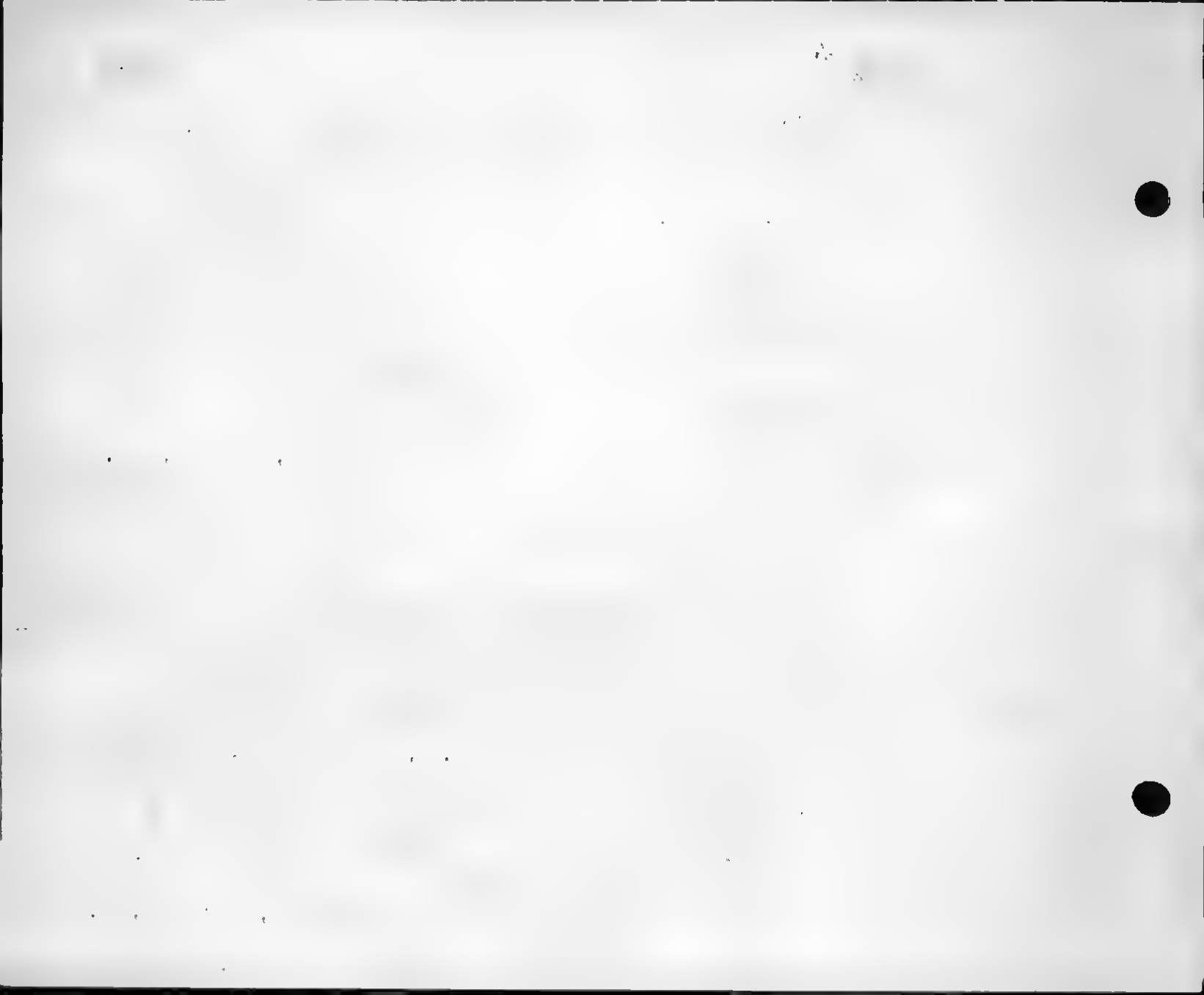
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04434

CERTIFICATE OF DEATH

04435

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 71 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance 19-2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS --	
3 NAME OF DECEASED (Type or print) First OLIVE Middle SARAH Last WHITELOCK		4. DATE OF DEATH Month 3 Day 15 Year 19 67	
5 SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 24 1872
9. AGE (In years last birthday) 94 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR IND. STRY household	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Arminger		14. MOTHER'S MAIDEN NAME Mary Willing	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Charles Whitelock, Chance, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) --		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 3, 1967 , to Mar. 15, 1967 , that (I) (we) last saw the deceased alive on March 15, 19 67 , and that death occurred at 2:20PM , from causes and on the date stated above.			
22a. SIGNATURE Andrew C. Mitchell		22b. DATE SIGNED 3/15/67	
22c. PHYSICIAN'S NAME (Type) Andrew C. Mitchell		22d. ADDRESS Deer's Head State Hospital, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 3/17/67	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Chance, Somerset, Md.
24. FUNERAL DIRECTOR Leroy B. Webster		25. REC'D BY REGISTRAR Princess Anne, Md.	
25a. DATE 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04433 CERTIFICATE OF DEATH 04436

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN ID 4 mths	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wicomico Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WALTER Middle WISSERT Last WISSERT		4. DATE OF DEATH Month March Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 6, 1880
9. AGE (in years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Rudolph Wissert	
14. MOTHER'S MAIDEN NAME Elizabeth Widner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 135-03-5346		17. INFORMANT Mr. Thomas O. Tyler, Vienna, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Arteriosclerotic Cardiovascular Dis. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate		INTERVAL BETWEEN ONSET AND DEATH Wissert Yes Yes.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from now 19 66 to March 8, 1966 , that (I) (we) last saw the deceased alive on Feb 6, 1967 , and that death occurred at 11:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Rufus S. Gardner, M.D.		22b. DATE SIGNED 3/11/67	
22c. PHYSICIAN'S NAME (Type) RUFUS S. GARDNER, M.D.		22d. ADDRESS MEDICAL CENTER, SALISBURY, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR LeCompte Funeral Service, Cambridge, Maryland		25a. REC'D BY REGISTRAR MAR 15 1967	
25b. REGISTRAR'S SIGNATURE J. J. J. J.			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04436

CERTIFICATE OF DEATH

04437

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna	
3. NAME OF DECEASED (Type or print) First GEORGE Middle EDWARD Last WONGUS		4. DATE OF DEATH Month 3 Day 31 Year 67	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/11
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John WONGUS		14. MOTHER'S MAIDEN NAME Lizzie CAMPER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-22-1950	
17. INFORMANT Mrs. Irene Pinder, Vienna, Md., RFD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of stomach with wide spread metastases DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 yr (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 28 , 19 67 , to March 31 , 19 67 that (I) (we) last saw the deceased alive on March 31 , 19 67 , and that death occurred at 9:45AM , from causes and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott M.D.		22b. DATE SIGNED 3/31/67	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M. D.		22d. ADDRESS Deer's Head State Hosp., Salisbury, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 13, 1967	23c. NAME OF CEMETERY OR CREMATORY Cross Roads Cemetery	23d. LOCATION (City or Town) (County) (State) Near Vienna, Maryland
24. FUNERAL DIRECTOR Frankton Funeral Home Frederick Md.		25a. REC'D BY REGISTRAR APR 6 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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